THE CANADIAN NURSE

PERIODICALS R. R.

VOLUME 53 NUMBER 4
MONTREAL

Highlight for
APRIL 1957

TWO HATS
M. L. RICHMOND

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THE CANADIAN NURSE

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APRIL 1957

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Between Ourselves

LIKE THE PRAIRIE BREEZES that can melt away mountainous snowdrifts that may be blocking highways, our guest editor has written of the way their committee organization is smoothing out the problems of welding all of the divergent interest groups in nursing into actively functioning bodies. Perhaps one of the most effective factors in the new program is the ardor and enthusiasm, the understanding grasp of the needs and the thoughtful consideration given to Alberta's nursing problems by the president, **Elizabeth Anna Bietsch.**

Born at Winnipeg, Miss Bietsch's family moved gradually westward. Her schooling was started in Saskatchewan, completed in Alberta. Following graduation from the Edmonton General Hospital, she joined the staff there as a head nurse and served in the medical and surgical departments before becoming night superintendent. After a year out for study in methods of teaching and supervision at the University of Alberta, Miss Bietsch returned to E. G. H. as nursing arts instructor, later moving into the nursing school office as assistant director of nurses, in charge of both nursing education and nursing service. In 1953, she became the director of nursing service and principal of the school of nursing at the General Hospital in Medicine Hat, Alta.

Equally thorough was Miss Bietsch's background of experience in preparation for her rise to the presidency of the Alberta Association of Registered Nurses. President of her own hospital alumnae association for four years, membership on and chairman of vitally active provincial association committees, she was well equipped to assume her present role two years ago. We wish her well in the multitude of activities she is called upon to lead and guide.

* * *

Though Easter is traditionally the season of new spring bonnets, **Mary L. Richmond** is not discussing millinery creations in her article entitled "Two Hats." Rather, she set herself the task of clarifying her thinking on an important question that, at one time or another, must have crossed the mind of every director of nursing — what approach might be used to promote the concept of the director as a "consultant" in addition to her authoritarian role. You will learn how Miss Richmond worked out an acceptable solution to this problem of wearing two very different hats. We hear she is successfully putting it into practice too.

* * *

April is the month when the public's attention is actively focussed upon the work of the **Canadian Cancer Society**. Three separate articles present various aspects of the role the nurse may play in this major field of interest — by providing essential nursing care, by assisting with the educational programs, by making her personal contribution in support of the never-ending work the Society has undertaken. Each is important, each needs us. The solution to the problems of the causative factors of cancer may not be found for many years so our continuing support is vitally essential.

* * *

This is the third year that the articles dealing with aspects of comprehensive nursing care and written by Canadian student nurses have been carefully read and evaluated by a group of capable judges. In cooperation with the Macmillan Company of Canada, wide publicity is given to the annual competition. The number of articles submitted has increased though entries are received from less than a quarter of the schools of nursing in Canada.

The honor of leading in the judges' scoring goes to Miss **Elizabeth Scanlin** a third year student in St. Joseph's School of Nursing, Hotel Dieu, Kingston, Ont. The second prize, also for $25, goes to Miss **Viola Sureries** a senior student in the Saskatoon City Hospital. Honorable mention book prizes will be sent to: Miss **Beverley Grey**, Brantford General Hospital; Miss **Imelda Beetz**, St. Joseph's Hospital, Victoria; and to Misses **Phyllis E. Bakken**, University of Alberta Hospital, Edmonton and **R. Williams**, Calgary General Hospital, who tied for fifth place. Congratulations, girls! Keep on writing for us! Watch for all of these prize winning articles soon.

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Description—Each tablet contains: Reserpine 0.25 mg. and carbinoxamine maleate 2 mg. or reserpine 1.0 mg. and carbinoxamine maleate 4 mg.

Indications—For the treatment of agitated states, psychoses and hypertension.

Administration—One to 2 tablets 2 or 3 times daily.

CANTIL

Manufacturer—Lakeside Laboratories (Canada) Ltd., Toronto.

Description—N-methyl-3-piperidyl-diphenylglycolate methobromide, a postganglionic parasympathetic inhibitor with a selective action on the colon.

Indications—Relieves pain, cramps, bloating; curbs diarrhea and restores normal tone and motility to colon in ulcerative colitis, irritable colon, mucous colitis, spastic colitis, diverticulitis, rectospasm, diarrhea following gastrointestinal surgery.

Administration—One or 2 tablets 3 times a day preferably with meals and 1 or 2 tablets at bedtime.

DORSACAINE

Manufacturer—Smith-Dorsey Division of A. Wander Limited, Peterborough, Ont.

Description—0.4% Benoxinate hydrochloride in sterile normal saline solution.

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Manufacturer—E. R. Squibb & Sons of Canada, Limited, Montreal.

Description—Broad spectrum antifungal antibiotic. It contains the equivalent of 125 mg. of steclin (tetracycline HCl) and 125,000 units of mycostatin per 5 cc. teaspoonful.

Indications—Many common infections responding to tetracycline therapy—those caused by most pathogenic bacteria, certain large viruses, some rickettsiae, or Endamoeba histolytica. Mixed infections.

Administration—Treatment continued for 24 to 48 hours after symptoms and fever subside.

Dosage—Should be based on the steclin content. The minimum dose for adults is 1 gram of tetracycline each day in divided doses. Larger doses may be required in severe or resistant infections. A pediatric dosage schedule is enclosed with the product.

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Manufacturer—The Leeming Miles Co., Ltd., Montreal 28.

Description—Triethanolamine trinitrate biphosphate 10 mg. A chemically unique aminonitrate in sustained-release dosage form.

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ROLICTON

Manufacturer—G. D. Searle & Co. of Canada Ltd., Brampton, Ont.

Description—Brand of aminoisometradine, in scored pale green tablets 400 mg.

Indications—For diuretic effect in heart and liver conditions.

Administration—Usual dosage, 1 tablet twice daily with meals.

SALCAINE CREME

Manufacturer—Moore-Thompson-Clinger Limited, Hamilton.

Description—Contains: Benzocaine 7.5%, glycol salicylate 10%, methyl nicotinate 2%, capsicin 0.1%, base ad 100%.

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Manufacturer—Frank W. Horner Ltd., Montreal.

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N.B.: The School of Nursing also offers, for high school graduates with University Entrance, a *Basic Professional Course* leading to the degree of B.S.N.

For further information write to the

DIRECTOR, SCHOOL OF NURSING, UNIVERSITY OF BRITISH COLUMBIA, VANCOUVER 8, BRITISH COLUMBIA.

ATARAX

Manufacturer—Pfizer Canada, Montreal

Description—Brand of hydroxyzine, ataraxic agent. Used primarily for the tense or anxious patient rather than the psychotic or the hospitalized insane.

Indications—Anxiety reactions, psychoneuroses, psychosomatic illnesses, climacteric states, premenstrual tension.

Administration—Adults: 10-25 mg. 3 or 4 times daily. Doses should be given with meals and with a small amount of food at bedtime.

Children: 6 to 10 years usually one 10 mg. tablet 2 times daily.

Adjust dosage according to patient's needs.

THIOSULFIL-A

Manufacturer—Ayerst, McKenna & Harrison Ltd., Montreal.

Description—Each tablet contains: Sulfamethylthiadiazole 0.25 Gm., phenylazodiaminopyridine HCl 50.0 mg.

Indications—A urinary anti-infective and analgesic in urinary tract infections. Contraindicated in renal and hepatic failure.

Administration—Adults, 2 tablets 4 times daily. Fluid intake should be limited; if voiding occurs during the night an extra tablet should be taken.

TROPH-IRON Tablets

Manufacturer—Smith, Kline & French Inter-American Corp., Montreal 9.

Description—Each tablet contains: Vitamin B_{12} 25 mcg., vitamin B_1 10 mg., ferric pyrophosphate 250 mg.

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Manufacturer—Sharp and Dohme Division, Merck & Co. Ltd., Montreal.

Description—Vitamin K, tablets of 5 mg.

Indications—Treatment of nonemergency hypoprothrombinemia as in sprue, ulcerative colitis, celiac disease; inadequate endogenous production of vitamin K owing to suppression of intestinal flora by oral sulfonamides or antibiotics; neo-natal deficiency of prothrombin; hepatic disease.

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School of Nursing

1957-1958

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For additional information, write to:

School of Nursing,
McMaster University, Hamilton, Ontario

New evidence from heart research laboratories indicates that hyperlipemia, a condition of excess fats in the blood, may result from deficiency of an enzyme, lipoprotein lipase, which normally acts to break down blood fats.

Lipoprotein lipase has been shown in earlier studies to aid in normal fat transport by breaking down the large fatty particles which enter the blood from digested food, into smaller particles which can then be utilized by body cells. The presence in the blood of abnormal quantities of the larger fatty particles is known to be associated with disease states which lead to atherosclerosis. Hyperlipemia is one of several such disease states. Its victims may develop atherosclerosis and coronary disease if they are not treated.

In normal persons dietary fats are broken down and removed from the blood within eight hours after eating. Injections of heparin are known to speed the removal of dietary fats from the blood of normal persons by activating lipoprotein lipase. Heparin injections have little or no effect on the "creamy" blood plasma of the hyperlipemic patient.

This finding pointed to a probable deficiency of lipoprotein lipase, but left open the possibility that the fat particles themselves might be abnormal and might be resisting enzyme action.

The effects of protamine, which slows the action of lipoprotein lipase were investigated. It was found that protamine had no effect on the transfused fats in a hyperlipemic patient, though it greatly slowed their removal from the blood of a healthy volunteer. "The simplest explanation for these observations is that the subjects studied have a congenital deficiency of tissue lipoprotein lipase." —U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE

Canada ranked twelfth among other countries in the rate of infant mortality in 1954. Sweden now has the lowest rate of 18 deaths per 1,000 live births, down from 61.4 during the years 1920-24. Canada's rate in that period has dropped from 104.3 to 32.

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II. Degree Course for Graduate Nurses (B.Sc.):
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For information apply to:

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UNIVERSITY OF ALBERTA
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Applications for this position should include a curriculum vitae, passport size photograph and names of three references, and should be sent to the

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Nova Scotia Hospital
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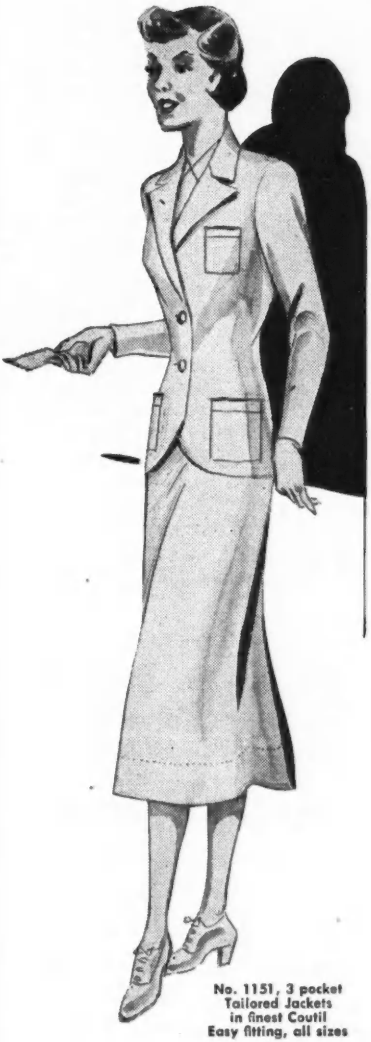

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Miss H. M. Lamont, Director of Nursing, Royal Victoria Hospital, Montreal 2, Que. or Miss Kathleen Marshall, Supervisor of Nurses, Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal 2, Que.

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Session 1957-58

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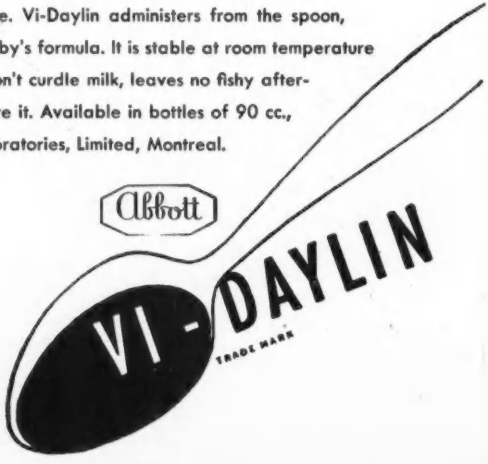

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THE CANADIAN NURSE

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Changing Concepts

FUNCTIONING UNDER our new committee structure for the past year has been a most gratifying experience. It is taking us a while to emerge from the cocoon of tradition in which almost each one of our members had a special little shell in which she could find protection and nourishment for her professional appetite. Now, each one of us must be aware of *Nursing* — the optimum care of the sick whether it be in the hospital, the home, or within our community. Nursing does not imply bedside care alone, it also embraces nursing education — for without nursing education we cannot expect to have qualified people to care for our sick. One is totally dependent on the other whether it be on a student or graduate level.

Both of our major committees — Nursing Education and Nursing Service — follow the same structural pattern. They are comprised of Central, Northern and Southern Branches and their activities are guided and collated by an Executive Committee, representative of all interest groups, under the leadership of the provincial chairmen. The Committee on Nursing Education had the advantage of starting to function under the new pattern in the fall of 1954. It continued its activities from the former "Instructor's Group" organized in the three regions. This Committee had to widen the protective spread of its wings to include the various interest groups and then proceed to keep everyone busy.

The Committee on Nursing Service has the task of reaching the nurses responsible for planning, supervising

ELIZABETH M. BIETSCH

and administering bedside care. An overwhelming assignment — but it can be done if the nurses realize that it must be a two-way communication to each of the branches and from there to the provincial committee. Meager sustenance is often the fate of our committees — but with an active membership of 3,307 they should experience gluttony as a result of receiving so many ideas and suggestions. One request from several of our inactive nurses has resulted in an outline for a refresher course that has been prepared and distributed to all our districts and chapters. It has already been followed in several areas with resulting interest and stimulus.

We felt the urgent need for establishing qualitative and quantitative standards to ensure good patient care. As a result we had a work conference last January to acquaint those responsible for nursing service with the existing standards which could be used. We are well aware that standards of nursing service can be used as a guide only.

The work conference was directed by Miss Margaret Street, Chairman of the Committee on Nursing Service and 38 of 116 hospitals were represented. The participation was excellent — even the students enrolled in the course in teaching and supervision at the University of Alberta felt free to share ideas with those who had had several years of experience. The mathematics required to plan staffing patterns for our hypothetical hospital situations had our minds whirling and kept our pens in constant motion. I am certain that harassed expressions such as ours could not be matched! All realized, in a very short time, that these patterns, based on specified standards, are useless unless we have effective utilization of our nursing service personnel and sufficient auxiliary help to ensure that the valuable professional hours of duty are used for nursing and not spent in performing clerical work, messenger service, etc.

Hospital administrators, boards of trustees and budget-control groups are equally concerned with standards of nursing service. Nearly 60 per cent of all hospital personnel are assigned to the nursing department. We are all cognizant of the dynamic manner in which the quality of nursing care affects public relations in regard to hospitals and professional organizations. The Department of Public Health, the Hospital Insurance Planning Committee, and allied organizations are, of necessity, keenly interested in the qualitative and quantitative standards of patient care. Consequently, we invited representation from all these groups to attend the final morning session of our work conference at which time the findings and conclusions were reviewed and discussed. The participation of all was most enthusiastic, mutual needs were expressed, and we went home feeling that the first step had been taken — we recognize the problem.

Considerable work has been done by the branches of the Committee on Nursing Education in evaluating the curriculum of our three-year programs, check list of abilities, accreditation and many other aspects of nursing education. Space does not permit me to give details, but a large number of our members are now working with us towards achieving and maintaining a higher professional status.

The problems are many and we must perforce change our concept of nursing. Although the patient still remains the center of all our activity, we must sacrifice some of the satisfaction resulting from the giving of tender loving care. We must recognize that the supervision of the care of the patient is fully as important and immeasurably more demanding than the actual giving of that care. We have to relinquish some of our functions to trained auxiliary personnel and still maintain in our trust the safety of all patients.

We are moving ahead — there are many rocky crags to challenge us and just as many comfortable plateaus surrounded by chasms of discouragement and defeat. We must keep on climbing — it is expected of each one of us who has devoted her life to the service of others.

"I find the great thing in this world is not so much where we stand, as in what direction we are moving." — Oliver Wendell Holmes.

ELIZABETH A. BIETSCH, President, Alberta Association of Registered Nurses.

Two Hats

MARY L. RICHMOND, B.N., M.A.

CONSULTATION is essentially a helping relationship. It is a

> process by which expert knowledge and skills are transmitted in a relationship between consultant and consultee for the purpose of problem-solving. The methods of this process involve teaching and/or helping through discussion and demonstration. The process of consultation derives its validity and effectiveness generically from the authority of knowledge and skills, and from the way in which it is conducted.[12]

While this concept does not conform to our traditional concept of the executive, director or authority figure, it does seem to come close to the emerging philosophy of the executive as a leader,[1, 2, 3] and to that concept discussed by Finer[4] and others in which authority has its roots, not so much in a designated status position as in skills and knowledge, and which derives its dynamics from the group acceptance of the authority.

It would seem that, like the consultant, the executive requires:

(a) Expert skill and knowledge in her field of specialization.

(b) An understanding of human nature as it manifests itself in the individual, and in her interpersonal and group relationships.

(c) An ability to identify, analyze and solve problems, and to enjoy doing this.

(d) An ability to maintain good and purposeful working relationships.

(e) A knowledge of the basic principles of teaching.

(f) Acceptance of the philosophy that people grow and learn by solving their own problems.

(g) A recognition of the fact that people accept change which is evolved within the framework of their own understanding and which does not threaten their basic security.

(h) That change must be made in harmony with the social setting and the value and power system that prevails.

That these attributes in the executive build morale, and thereby increase both financial returns and human satisfactions in a business enterprise, are the key-notes of the emerging philosophy of administration. A reasonable basis for such a philosophy is attested by the current research and scientific study in the social sciences.

What then, is the difference between the consultant and the executive?

They have different traditions, different stereotypes, and different roles. One has been the *helping* figure, the other the *authority* figure. Within the framework of an organization, the consultant's position is "staff," the executive's position is "line." The consultant has been an expert giving advice to a fellow practitioner. The executive has been a commander issuing directives to a subordinate. The consultation has been sought, and the consultee free to accept or reject it. The command has been imposed, without choice of obedience. While the consultee was bound by his own conscience in acceptance of superior knowledge, the subordinate was bound by loyalty or fear.

Can these roles, of consultant and

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executive, be reconciled within one individual — in the person of the director of nursing?

The answer is primarily "NO" for two reasons. First the nature of the job, and secondly, the groups' expectations of the director.

The director of nursing has a *line* position, with authority and responsibility within the framework of the organization. Decisions have to be made and orders have to be issued.

> Line management has the full and final responsibility for directing the activities of the people who comprise the organization because line management is directly responsible to the founders or owners for achieving results through those people. Consequently line management must retain the full authority to carry out the functions for which it is responsible.[5]

By and large, the nursing staff in a general hospital has not only accepted the director as an authority figure, but they have not had those kinds of experiences which enable them to accept consultants. Both their preparation for professional practice, and the practice itself, have offered more opportunity to accept data and dicta, than to engage in genuine problem-solving with the help of an expert as required. Doctors, administrators, directors and supervisors — all are more schooled in issuing commands than in participating in group work.

This has been ostensibly justified on two grounds — the lack of any number of well-prepared people who could function otherwise, and the life-death crises situation within the hospital. That these circumstances still exist make the position difficult to abandon.

The director of nursing, herself a product of this tradition, yet wishing to fill more nearly the role of consultant, will have to recognize and accept this. As Miss Frazier has said:

> The past experiences of both (the consultant and the consultee) in relationship to expectations of authority figures, may influence the ability of the consultant to help the consultee move from a relationship of dependency to independency.[6]

Yet the "YES" to the possibility of reconciliation of these roles presents a challenge. I believe the weight of evidence of social research and experience, necessitates that there must be some such reconciliation, if the director of nursing is to become a leader who can both attract desirable candidates into the profession, and develop a growing staff who will become the kind of people who can give expert, understanding, patient-centered care, and who will find increasing personal satisfaction in nursing.

> The successful performance of either the line or the staff function appears to require the creation of a relationship within which the consultee can simultaneously increase his own need satisfaction and contribute more effectively to the achievement of organizational objectives. The genuine motivation of subordinates to cooperate with their superiors toward the achievement of organizational objectives will not occur so long as the line function is tacitly assumed to rest solely upon the line manager's exercise of reductive authority.

Some guides might be followed by a director who wishes increasingly to be used as a consultant by the staff of a fairly typical and traditional hospital:

> The director of nursing must, in part verbally as well as in her deeds, paint that picture of herself to her staff. She should define her position, as she sees it, to her staff. She can discuss consultation as a process and an evolving field of professional practice. The general admiration of the nursing staff for the physician who will call in a consultant out of his own skill rather than his ignorance, seems one good starting point. She can make available to the staff, current literature which reflects her feeling about consultation and about the executive, and let the staff know that this is shared thinking.
>
> She should herself adopt a problem-solving approach to situations. By refraining from the pat answer, she should encourage the staff, as a group and as individuals, in thinking through problems, and in utilizing resources outside themselves.
>
> She can create an atmosphere in which problem-citing is a manifestation of ability rather than inadequacy, and in which it is comfortable both to raise questions and to make mistakes in their solution.

She should accept the priority of problems as the staff sees them, rather than as she sees them, recognizing that only a truly felt problem calls forth effort toward its solution.

She, realizing that the staff's experience is not hers, should not push the group at a pace too much beyond them. She must lead, but not drive. To the extent that the director establishes priority of issues and steers the solutions, she slips from her role as consultant. As has been warned, a reformer cannot be a consultant.

She must build up the staff's confidence in its own problem-solving. Success brings confidence and renewed efforts. The staff should be guided in selecting problems which are capable of solution with or without help. If problems are incapable of solution, improvement should be recognized as partial success. The staff should be given credit for solutions and improvements which it evolves. The director's recognition of the staff's contribution is itself some reward, but credit should be given in the eyes of the administrator and the public when occasion permits.

The director should let her staff know that she sincerely believes that such a problem-solving approach will yield better solutions than she alone is capable of. While both her status position and her preparation tend to make her an "authority," she should endeavor to genuinely incorporate her contribution into a group decision, so that insofar as possible, it is both made in response to a request, and merged within the total solution which represents group thinking. Her distance from the group, in terms of actual "expertise" will be reduced by her endeavors to engage a staff who are themselves well qualified by preparation and experience. She should feel strengthened rather than threatened by experts on her staff.

Those areas in which her authority is exercised must be made clear, and distinguished for the staff and in her own thinking from those areas in which she is truly seeking to act as consultant. She should not try to fool either her staff or herself. They should both recognize the difference between giving information and giving orders. Some decisions have to be made apparently arbitrarily. These should be kept to a minimum, and be defined by the nature of the problem and not by the mood or whim of the director. She must have a consistent philosophy of what kind of issues she wishes to become group problems. If, in a specific situation she rejects group decision, she must be honest in stating that she has, and why she has.

The director should create situations in which she can get to know the staff, so that they will feel comfortable in sharing ideas with her. While the consultant acts essentially in a problem-solving situation, she should not meet the consultee only in crises. There should be occasions which build up rapport, so that the tensions, anxiety and threat of the crises situations are minimized. (Such occasions include routine interviews, ward visits, staff meetings, in-service education programs, shared study programs, or social functions.)

The director should reflect her own acceptance of outside consultants as sources of help to her. She should recognize the expert beyond herself, in the person of either a designated nursing consultant, an executive of the professional association, a member of the university nursing division, or the expert adviser outside nursing. Such recognition not only builds up professional pride, but establishes a feeling for the "respectability of needing help."

She should evaluate the specific situation in which she is to function, and glean as much information as she can about the community and the hospital, and the value and status systems that prevail. The formal organization chart should be studied, but so should the informal organization be sensed and studied. She might be helped by some knowledge of her predecessor — her attitudes and practices — and, if possible, the expectation which she built up of her successor.

Finally, the director should see herself as a student — in the sense that she approaches many situations as a learner, open to teaching and advice; as an experimenter guided by some sound principles, but eager to see the reasonably predicted results in a specific situation; as a member anxious for the team relationship with staff members as fellow learners; and as a person growing in knowledge and abilities, yet capable of making mistakes.

By such measures I believe, a direc-

tor may effect some change toward her role being seen by her staff as more nearly that of a consultant — the teacher, adviser, and helper. I believe that such a role will not only enable her to be a more effective person, but will yield her richer personal satisfactions. I do not believe it is always an easy transition for either director or staff.

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Provisional Program
Eleventh Quadrennial Congress of the ICN

MAY 27 — JUNE 1, 1957

MONDAY, MAY 27 — *Opening session — addresses of welcome*
President's address
Open meeting of Grand Council

TUESDAY, MAY 28 — *Grand Council Sessions*

WEDNESDAY, MAY 29 — *Grand Council Sessions*
Congress theme — **RESPONSIBILITY**

THURSDAY, MAY 30 — ***Responsibility for the Selection of Nurses***
Papers on: *a)* Needs of the profession
b) Needs of the community
General discussion

FRIDAY, MAY 31 — ***Responsibility for the Education of Nurses***
Papers on: *a)* Role of the nurse in the total health program
b) Responsibility for basic preparation
c) Responsibility for postbasic preparation

SATURDAY, JUNE 1 — ***Responsibility for nursing administration***
Papers on: *a)* Principles of administration
b) Application to nursing education
c) Application to nursing service
Address of retiring president
Introduction of new slate of officers
Address of new president

La Physiologie Cardio-Pulmonaire

EMILIEN LABELLE, M.D.

DEPUIS quelques mois, un nouveau service fonctionne à l'Hôpital Sainte-Justine: le service de Physiologie Cardio-Pulmonaire. Cette dénomination aussi bien que la discipline qu'elle identifie ne manquent pas d'en intriguer plusieurs. Cela se comprend. Bien que de cristallisation assez récente, cette discipline de laboratoire clinique est déjà installée et appréciée dans tous les centres médicaux importants tant européens qu'américains. Chez nous, les institutions dotées de l'instrumentation nécessaire et les individus spécialisés dans ce genre de travail se comptent facilement et depuis peu sur les doigts d'une seule main. Oh! on sait, que c'est dans ce département nouveau, au sixième étage, que se pratiquent les cathétérismes du coeur . . . et c'est à peu près tout ce qu'on sait de ce département que l'on confond volontiers, inconsciemment, avec la Cardiologie.

Il y a plusieurs épreuves fonctionnelles, outre le cathétérisme du coeur, en Physiologie Cardio-Pulmonaire. Certes, il y en a pour étudier spécifiquement chaque "moment" dans l'accomplissement de la fonction cardio-pulmonaire, i.e. respiratoire.

Précisons les termes. Au lieu du qualificatif cardio-pulmonaire, on pourrait employer comme le font souvent les anglo-saxons — celui de cardio-respiratoire. Nous nous en abstenons pour éviter de blesser l'architecture linguistique. Plus succinctement, on pourrait dire la physiologie respiratoire. Cette expression serait la plus juste. En effet, Wiggers définit la respiration comme:

> L'ensemble de tous les processus par lesquels les cellules sont approvisionnées en oxygène et libérées du bioxyde de carbone produit durant la combustion.

Cette définition pose les cadres de notre discipline. Toutefois, une coutume mal fondée rattache le concept de respiration exclusivement aux poumons. L'expression cardio-pulmonaire fut mise de l'avant principalement pour corriger, par l'accolement des termes, ce concept restreint et faux de la respiration. Les "moments" respiratoires dont il fut question plus haut, sont des divisions parfois réelles, parfois arbitraires dans le travail accompli par les différents systèmes intégrés. Ainsi la respiration se trouve commodément segmentée en quatre grands chapitres: 1) la ventilation, 2) la diffusion, 3) la circulation, 4) le métabolisme. Chacun de ces chapitres se subdivise ensuite selon divers aspects fonctionnels pour la facilité de leur étude, d'où le grand nombre de tests existants et projetés, d'où la nécessité de leur interprétation dans leur ensemble et dans le contexte clinique puisqu'il s'agit "d'expliquer" un malade. Ces épreuves fonctionnelles ne constituent pas un but en soi. Ce sont des instruments de travail, des compléments aux méthodes d'investigation cliniques habituelles. Ces examens ne sauraient se substituer à une histoire de cas bien faite, une exploration somatique complète, etc.

Les patients que nous voyons le plus souvent appartiennent à deux groupes symptomatiques: les *dyspnéiques* et les *cyanosés*. Certains appartiennent aux deux simultanément, et le gros problème parfois peut consister à préciser si le vice fonctionnel est pulmonaire ou cardiaque à l'origine, car des troubles de la ventilation tout autant que des troubles de la circulation peuvent entraîner également dyspnée et cyanose. Une ventilation insuffisante, soit par déficience mécanique de l'appareil musculo-osseux de la cage thoracique, soit par défaut de distribution de l'air inspiré, soit par mélange intra-pulmonaire imparfait des airs, amènera une dyspnée. L'efficacité ventilatoire étant prise en défaut, le métabolisme tentera bien pour un temps de s'habituer à ce ralenti, mais ne réussira pas toujours ni pour longtemps et l'hématose insuffisante provoque l'anoxémie et sa manifestation clinique: la cyanose.

Une circulation insuffisante, d'autre

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part, ne saurait profiter d'une ventilation adéquate, et les mêmes anomalies apparaissent. Il ne suffit pas de bien aérer les alvéoles pour assurer les échanges gazeux. Il faut la présence en quantité suffisante de sang veineux à transformer. Il faut une certaine balance entre l'apport gazeux et l'apport sanguin. Un shunt intrapulmonaire ou intracardiaque brise ce rapport. C'est ainsi que les angio-cardiopathies congénitales viennent perturber la fonction respiratoire. L'attention préférentielle que nous accordons actuellement à l'étude des malformations congénitales du coeur et des gros vaisseaux s'explique bien. De plus en plus nombreuses sont les malformations susceptibles de correction chirurgicale. Une telle correction doit s'adresser au départ à une lésion bien déterminée. La précision du diagnostic est essentielle ici. Dans certains cas, les études fonctionnelles, dites d'hémodynamique, apportent la solution à un diagnostic différentiel complexe.

Le cathétérisme du coeur ne constitue *qu'une* des épreuves variées de la Physiologie Cardio-Pulmonaire. C'est peut-être la plus spectaculaire et sûrement celle qui fut la plus longtemps désirée!

En plus de son travail de diagnostic, le Service de Physiologie Cardio-Pulmonaire s'occupe de recherches. Il y a d'abord des recherches de base, il faut recueillir des données normales, pour les groupes d'âge qui n'en ont pas encore. Ces "normales" permettent les prédictions et les comparaisons lorsqu'un malade est étudié. Il y a la conception de méthodes et d'appareils nouveaux pour pouvoir obtenir chez certains malades particuliers les données essentielles à l'élaboration d'un diagnostic physiologique. Les nourrissons présentent des problèmes quand les tests dont nous disposons actuellement demandent la collaboration du malade.

Voilà rapidement tracée la silhouette de la Physiologie Cardio-Pulmonaire du sixième. Elle encercle encore beaucoup plus de promesses et d'espérances que de réalisations mais avec le temps nous avons confiance de justifier notre présence et nos dépenses.

Sélection

Le traitement des grands brûlés

Le traitement des grands brûlés peut maintenant être considéré comme standardisé. Il a transformé le prognostic des brûlures étendues non seulement au point de vue vital mais aussi dans ses répercussions sociales et il n'est pas inopportun d'en rappeler les grandes lignes (Rudler, Médecin d'usine, No. 9, 1953.)

Traitement au poste de secours

En attendant le transport d'extrême urgence dans un service spécialisé, pratiquer, par voie endo-veineuse, une injection de morphine et commencer une perfusion de plasma ou, à défaut de subtosan ou de sérum physiologique.

Ne pas déshabiller le brûlé, protéger les brûlures exposées par une alèze stérile et s'abstenir de toute thérapeutique locale et générale, notamment par voie intramusculaire, ce qui risquerait d'entraîner des accidents graves, par résorption massive, au moment du déshockage.

Traitement hospitalier

Pendant les six premières heures: C'est la période initiale du shock qui correspond à l'extravasion de liquide sanguin des vaisseaux vers l'extérieur, conséquence d'une perméabilité capillaire accrue, et qui s'accompagne d'une anoxie plus ou moins sévère, d'acidose et de troubles du métabolisme chloruré sodique.

Il faut lutter contre l'ensemble de ces manifestations humorales qui atteignent leur maximum dans les six premières heures et n'augmentent que progressivement par la suite, par un traitement de réhydratation.

Dans les premières 24 heures: Pour chaque 1/100 de surface brûlée on donne 75 cc. de plasma et 75 cc. d'une solution d'électrolytes non colloïdale.

La moitié de la dose totale est injectée dans les 8 premières heures et la seconde moitié dans les 8 heures suivantes.

Lors de la seconde journée on diminue la

(suite à la page 328)

New Concepts in Geriatric Nursing

JANET R. BROWN

WHEN WE SPEAK of the medical care of the elderly, we use the term "geriatrics" which is derived from two Greek roots: Geron — an old man; gatrious — medical care.

The aim of geriatric nursing is to prolong life, not in misery but in comfort. The mission of geriatrics has been to blow like a strong fresh breeze, clearing away the dust and cobwebs of out-moded concepts of care for the aged. Put in medical terms, its mission has been to preach that sickness in old age is not necessarily irremediable, that even if the cause is incurable the symptoms may be alleviated and the body rehabilitated for useful life again. Old age need not be a time of stagnation and decay, but with new ideas and attitudes may be a time of new hope and happiness.

It is certainly a fact, that, just as society has infants, it will always have elderly people, unless of course someone finds the fountain of youth! But what does society do about its elderly people? Society says it has a problem — "the problem of the aged." We must meet that problem now, or very soon the aged will be our biggest burden. We never hear about the infant problem, because infants are recognized as members of society, and are fitted into the social pattern. Why then can't we show these older people the same love and charity that we give to our infants and other groups of society?

Some of these older people who enter our D.V.A. hospitals may or may not be ill. Those who are not ill come to us because they have no home in which to spend their declining years. Those who are ill, may or may not have a home, but cannot receive proper medical or nursing care outside the hospital.

Relatives sometimes think that as soon as Grandpa enters the hospital his noisy spells are over, he no longer worries about people trying to steal his money. They think he should immediately be able to hop about like a boy scout and take his meals like a lumberjack. Consequently, on visiting days when Grandpa is up to his old tricks, relatives may assume that the hospital is a failure of the first order. To dispel such conclusions, we must cultivate favorable public relations with the relatives and friends of the patients. They must be educated, in a gracious and gradual way, to a better understanding of the hospital and of the old folk whose home it has become. Frequent visits should be encouraged and the needs of the patients — such as new clothes or more changes of clean clothing — should be made known to the relatives and friends. To do this, various services and organizations within the Department of Veterans Affairs are enlisted. The relatives must be brought to realize that the care of the patient is a responsibility to be shared by them and the hospital.

As nurses, we must realize that we are caring for living human beings who have grown old according to the particular pattern of life in which they live. The pattern differs from one person to the next. To harmonize them all is a task which requires daily attention. A nurse who cares for the aged should observe the highest standards of nursing care and should deal honestly with the patient.

We are inclined to forget how much the older patient depends on the nurse. For some patients the nurse means sight, for others hearing; the nurse provides the arms for those who cannot use their own, the legs for those who cannot walk, and the back for those who cannot turn. For all she provides essential social contact.

Service to the patient must flow from the heart of the nurse. The greatest asset of the nursing profession is the love it has for its patients, for where there is love, there is no labor. The desire to serve is important because service to the patient is frequent-

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ly rendered unnoted. Frequently no one but the nurse rendering the service knows whether the quality is good or bad, effectual or not. A sensitive conscience and a feeling of responsibility are requisites for anyone put in charge of elderly patients, whose welfare is determined by the mercy of others.

Old age, especially sickness in old age, may be thought to be dirty, distasteful and depressing and that the patients themselves have no interest in their personalities or diseases. The nurse who thinks in this way may visualize a chronic sick ward filled with bedridden, incontinent patients. Old age can be, it is true, dirty, distasteful and depressing. *But*, properly approached the nursing care of the elderly sick can be one of the most rewarding branches of the profession of healing. The salvaging of wrecked lives and broken bodies brings with it a satisfaction which cannot be surpassed. Too often we hear the expressed opinions that old people are just vegetating — they are useless, so why bother? Those useless people who are vegetating are human beings, just as you and I. Their human value does not decrease just because their years increase. Certainly they are more human than those who write them off as a waste of time and treatment.

Special Needs

The special needs of the older patient are both physical and psychological.

Physical Needs: The physical requirements of the older patient must be based upon his specific needs.

Usually the older patient is susceptible to cold because he has lost much of his subcutaneous fat. He needs adequate bedding, protection from drafts and enough clothing to keep him warm when he is sitting on a chair.

Aged skin has lost its original functional quality, its ease of cellular repair, the subcutaneous fat and the ability to react to abuse. The epidermis furnishes less protection. The skin is dry and needs less bathing. The older person who insists that two baths a week are enough may be more nearly right than his overambitious nurse. Since feet and legs are prone to dryness and itching, daily massage with oil or cream is often much better that bathing.

With bed patients, of course, special care must be given to the back and other pressure areas.

Since his temperature-regulating mechanism is less efficient, he is also more susceptible to extreme heat. Burns are apt to be more severe, because his skin sensitivity has been lessened and his circulation is poor; hence the need for extreme care in the use of hot water bottles and heating pads.

Older patients require a lower caloric intake than in earlier years, but the diet must be balanced and fluids adequate. Food should be soft and easily digested. Due consideration should be given to missing and defective teeth. Gas-forming foods should be avoided as much as possible.

Incontinence of urine may be a problem which most of us have to face in our nursing care of the older patients. Catheterization twice a day may help to control the bladder; antibiotics may be used and if all measures fail, a Foley catheter may have to be used. The latter, however, is a dangerous procedure on grounds of infection, and one not likely to be tolerated by the restless patient. In any case, the incontinent patient must be kept clean and dry.

The nurse who is aware of the possibility of fecal impaction can suspect its presence by the patient's complaints. One of the chief symptoms is the persistent diarrhea. A gloved finger examination of the rectum will enable the presence of the condition to be recognized.

Repeated enemata, interspaced with oil retention enemata help relieve the situation. Not infrequently a three weeks' period with mild purgatives is required before the bowel can be pronounced empty.

Restlessness, especially in senile psychoses, is a very big problem. Older patients may sleep during the day and wander around most of the night. The nurses' first duty is to try to find out the cause of the restlessness and with this aim in view, we can classify causes as follows:

1. Bodily discomfort, e.g. thirst, over-

heating, bladder or bowel distention.

2. Efforts to satisfy body needs, e.g. confused patients may be trying to find the bathroom.

3. Brain disease, cerebral congestion from cardiac failure. Cerebral anemia of varying causation. Cerebral catastrophe such as hemorrhage.

4. Metabolic upset.

5. Drug intoxication — a dangerous accumulation can occur in the system if administration is anything but brief. One of the principal symptoms of the accumulation is restlessness with confusion.

Restraint of the aged should be avoided as much as possible, as it usually serves to confuse and frighten him. In his efforts to escape, his fears increase and often physical collapse may result from his struggles. It cannot be emphasized too strongly that a nurse or orderly who applies or removes a restraint without a written order from a doctor, places herself in a potentially serious position. We may be held legally responsible if something untoward happens to the patient as a result.

Extra precautions must be observed in order to protect the patient from physical injury due to accidents. Adequate night lighting, double bannister rails on staircases, railings along corridors, attention to floor boards, loose rugs, worn linoleum, waxed floors (we use nonskid wax). Often the removal of wheels from beds makes it much safer for patients to get in and out. Bed rails should be used whenever indicated. Particular attention should be given to a safe passage to the bathroom unimpeded by small obstacles which may cause stumbling. Unsteady articles of furniture against which the patient may lean should be removed.

Confused, tremulous and partially paralyzed patients are very unsafe with cigarettes and matches and should never be allowed to light their cigarettes or smoke alone.

Every effort should be made to enlist the full cooperation of the patient, by explaining to him that any prohibitions are made entirely in his interests and with no wish to restrict his personal liberty.

Psychological Needs: The understanding nurse must have infinite patience, a sense of humor and must treat the older patients not as statistical errors but as human adults, who like all of us, have emotional needs that must be met if they are to have the hope, self-confidence and security that is essential for the peace of any person.

The achievement of rest, indeed the entire care of the aged depends more upon an understanding and proper management of emotional aspects than perhaps any other single factor. Without the fears imposed by illness, the aging and those caring for them must deal with the psychologic problems that are considered to be the normal occurrence in senescence. Nearly all aging persons show diminished physical and mental energy, a loss of memory for recent events, a weakening of initiative, and a tendency to become more set in their ways. They may not be able to tell you the year, month, day or hour it is, but they have a vivid recollection of the happenings of many years ago. They may tell you they haven't had breakfast, or a treatment the doctor ordered, and a few minutes later describe in detail events which happened years ago. They may tell you the same story over and over again, or that all of their belongings have been stolen. Listen with patience, don't brush them off! This is all very real to them.

The thoughtful nurse will remember that they, more than younger people, place their belongings where they may become lost or misplaced, or hide their money and other valuables in their clothing or bedding. Help the patient to look for his things. When they make mistakes or forget, they should be corrected with great tact — often not at all, for it is shattering for them to lose faith in your spoken word.

Often the nurse can establish fine rapport with older patients by showing an interest in events of years back and asking their advice in simple matters. This rapport may be helpful in combatting the natural resentment shown by the older person towards suggestions made to them by a younger person.

The older patient knows the world is passing him by, and wants to continue to be a participating member of his own group and of society. He has

established ways of doing things and his habits have become fixed. He wants to make his own decisions and to manage his own affairs, yet he feels his independence slipping away from him. He may have outlived his brothers and sisters and probably most of his friends and has to turn to strangers and those who are much younger for advice. In his daily living, he is frequently placed in a position in which he believes he is not wanted and is in the way.

His family and those who look after him seem to be planning his way of living without consulting him. He feels much disapproval over the way things are done. On the other hand, he may show a certain amount of regression, and his demands may be out of proportion to his illness. Such behavior stems from his desire for affection and assurance that he is wanted. It is difficult to remember that his irritation and resentment are not directed at the nurse personally, but are rather a rebellion against the circumstances in which he finds himself. The nurse is merely a symbol of all that is difficult in the world at the time.

The Nurse

The nurse's own attitude is of great importance in the attainment of emotional security for the older patient, and also in her personal satisfaction in working with this group. It is difficult for anyone of us to visualize ourselves as being old. We dread the approach of old age. We are not even sure that we will reach old age. Thus, for success in nursing the aging, our own attitudes must be understood, even to the extent of realizing that our reactions may, in part, be determined by a subconscious fear that we may eventually be placed in a similar position. In turn, our attitude is often responsible for the behavior of the older patient.

The nurse who remembers the importance of the need for a feeling of security is in a particularly good position to help in adding "life to years and years to life."

The nurse who understands the emotional factors in caring for the older patient will try to lessen the monotony and boredom that are likely to be present. She must be sure that the goals she sets are desirable and attainable such as, to encourage the patient to feed himself and to disregard or treat lightly resulting mishaps.

Discuss with him some of the happenings of the world beyond his bedside. Widen his world by placing his bed or chair by a window so that he can look out and see what is going on; so he can observe and if possible join in some of the activities of the other patients. She must give due regard to the limitations of his vision, his hearing, and to the fact that he may be a little slow in getting up, in eating his meals, or in making up his mind to swallow his medicine. A word of praise may well help to brighten a dull day.

The understanding nurse will have respect and sympathy when an old person hoards soap or other small articles in his bedside table. Never throw away anything belonging to him, no matter how small or trivial the article may be, without consulting him. It may seem to be of no value to you, but to him it might be the only possession he has.

The nurse can also contribute towards the prevention of mental deterioration by helping to bring emotional satisfaction to older patients, and by assisting their families and friends to understand their behavior and the reason for it. Many of these patients are misunderstood by their families who do not realize that many of the things they do or say are caused by their illness. We must accept the fact that they are *people* and not old crocks, some of whom might never have been sick if it had not been for our, and society's negligence. We can safely say, that there are few problem children or adults; there are, however, many problem families.

The care of the older patient presents some of the most rewarding experiences of nursing. For each patient who is senile and baffling, there are many whose response to a wise and understanding nurse brings manifold returns for her efforts.

We must direct our efforts at the young-old people. If we can devise means of keeping them at work, we can help them to rehabilitate themselves physically and mentally. If they are given adequate care in sickness and

convalescence, if they have normal opportunity for play, vacation, living and social association, many of them will retain their independence, and the break to custodial care will be of short duration, or will not take place at all.

Finally, to believe, as some nurses seem to believe, that the nursing care of the elderly patient can be provided entirely and quite satisfactorily by practical nurses and trained attendants, is to muff a golden opportunity. For nurses, to fail to take advantage of their particular responsibility in the care of the older patient, is to fail to make an important social contribution that is within their powers and that, indeed, can never be wholly met without their help.

Perhaps when a larger number of us learn how to cope satisfactorily with the psychological problems that are likely to be part of growing old, the oft-quoted lines of Browning can be spoken with conviction by a constantly increasing number of us.

Grow old along with me;
The best is yet to be,
The last of life, for which the
first was made.

Cold Feet

CATHERINE DE N. FRASER

MOST COMMONLY, when a nurse says she has "cold feet" she is figuratively describing an element of nervous fear, a shrinking from launching on a new venture, a hesitancy to accept some new responsibility. Occasionally, this variety of "cold feet" proves such a hindrance that the nurse misses opportunities she might have seized. Usually, however, she manages to overcome her timidity without too much stress on herself.

The physical discomfort experienced by the aged, bedridden patient whose feet are constantly cold means something entirely different. Although I recognize the risk of burning that may result from a hot water bottle and appreciate the reason why it frequently is banned, I do not feel that adding extra weight in the form of more blankets is a practical substitute. My plea is that suitable bedsocks be provided.

What is the objection to bedsocks for patients whose circulation is so poor that the extremities are always cold? I have come to the conclusion that the inadequacy of laundering facilities must be responsible for the decision to ban bedsocks which, I feel, would be a great comfort and add to the well-being of aged persons being cared for in institutions where the room temperature is generally only moderate and where, at times, the patient may be in a direct draft from an open window.

The particular instance that prompts these observations concerns a bedridden, deaf old friend who, not so many years ago was a stately old lady, very independent and with every comfort surrounding her. A fractured hip that has never shown any signs of mending, meant for her hospitalization and confinement in bed. To make sure she will not try to walk again safety sides are continuously on the bed. At first, when I visited her, I was worried because the tidy but tightly tucked bedding seemed to prevent any possible movement of the uninjured leg and also to press on her toes since she lies day and night in the same position on her back. Now, nearly two years later, a foot-board has been added which relieves the pressure on her feet.

What gave me a shock, though, was to *feel* her feet and find that they were cold enough to be those of a dead person! On calling this to the attention of a nurse, I was given permission to pull on a pair of bedsocks that had been

Miss Fraser, who graduated from Winnipeg General Hospital in 1906, has retired from nursing and resides in Montreal.

left for my friend by another visitor. To my surprise and annoyance, on my next trip to see her, my friend told me that I was scarcely out of the building before the socks were removed from her feet. Actually, I had brought with me a new pair of fine woollen ones that could not possibly have been thought too heavy for her to wear.

Can anyone answer my question? Why cannot aged people with cold feet be permitted to wear bedsocks?

Manitoba's Rural Hospitals

EARLY LAST YEAR as plans for the fall convention of the M.A.R.N. were being formed, The Canadian Nurse Committee under the convenership of Miss Beatrice Biron began work on a project of an original nature.

A letter was sent to all the smaller hospitals in the province requesting a short sketch of their historical development and a photograph. When all material was assembled, huge posters were constructed on which the picture of each hospital and its story were displayed. Over all was the slogan *"The Canadian Nurse* Communicates."

The Exhibit

Some of the hospitals were very new and their history was correspondingly short; others had seen a nation grow up and had grown along with it. The combined story of their development is interest-catching. To those of us absorbed in the work of larger centres and institutions, it emphasizes the very fine service being given by the smaller units — a fact that sometimes tends to be overlooked. Unfortunately space permits only two of these accounts but they are representative of the smaller institutions that are meeting the needs of rural and more isolated communities so well.

St. Anthony's Hospital, The Pas

ST. ANTHONY'S HOSPITAL in The Pas, Manitoba, came to life in March 1912 by the organization of a ten-bed hospital in the residence of His Excellency, Most Reverend Ovide Charlebois, Apostolic Vicar of Keewatin. The original building, a two-story wooden framework, was opened to offer shelter to patients of all creeds, races and nationalities who required hospital care. Four members of the religious order of Sisters of Charity of St. Hyacinth, generally known as Grey Nuns, ministered to the sick from a wide territory.

Standing alone, in the heart of a new country, extending from the prairies to the northern limits of civilization, the bed capacity very soon became inadequate to house all those seeking medical attention. They came by canoe in summer, by dogsled in winter, or were carried hundreds of miles over portages by willing relatives and friends. By 1914 it was deemed urgent to add another story to the existing building thus bringing the bed capacity to 50.

For 14 years through toil and untold hardships, St. Anthony's grew and prospered. Then the day dawned when the administration felt that the time had come to establish a more stable institution. Therefore in 1926 plans were drawn for a 185 x 50 foot structure of steel and stone fireproof construction, four stories high, with additional wings for kitchen, laundry and boiler room facilities. It was a costly enterprise.

All the building materials, as well as the equipment, had to be transported by rail for hundreds of miles. Through provincial grants and public assistance the new hospital became a reality and opened its doors on May 24, 1929.

Since its dedication, the sturdy grey brick walls of the hospital have waged a victorious battle against deadly cold, heavy winds and blizzards, and now stand as stately as the day they were built. Within these solid walls many transformations have materialized to meet the demands of a rapidly growing northern country and progress in medical sciences. The vast northern territory offers a challenge to ambitious young women. To help arouse the desire in nurses to devote themselves to missionary nursing in northern Canada, a brief description of the hospital's present facilities follows.

The ground floor houses the chapel, where religious services are held every day. The administrative personnel offices and admitting offices occupy the center and share this space with the main entrance. The remainder of this floor consists of public, semi-private and private wards for medical-surgical Indian patients. St. Anthony's Hospital receives patients from approximately 25 Indian reserves situated in Manitoba and Saskatchewan.

A modern obstetrical unit, renovated in 1955, is now complete with labor, delivery and scrub rooms, newborn and isolation nurseries. It occupies one wing of the second floor. A separate public ward is devoted to Indian mothers. In the other wing of this same floor is located the medical-surgical unit for all other patients.

On the third floor is the operating suite,

St. Anthony's Hospital

This consists of theatres for major and minor surgery separated by a scrub unit. Also found in this section are facilities for treatment of emergency casualties, plaster cast application, a central supply room and sterilization equipment. At the farthest corner of this wing is a recently remodelled drug dispensing unit. The Medical Records department occupies the center of third floor. The south wing is devoted to the x-ray department and clinical laboratories. Both departments are adequately equipped with the most modern machinery and apparatus. The laboratory was entirely renovated in December, 1955. The remainder of the south wing comprises the pediatrics department, which will be transferred to the fourth floor in the near future. This department is now inadequate to meet the requirements of an increasing number of patients.

In the basement you will find a modern cafeteria, a central linen unit and a recently organized ward for the the aged and chronic patients. Leading from this floor are two separate wings for the kitchen, the laundry, the boiler room and the workshop.

Today St. Anthony's Hospital stands as a symbol of achievement and prosperity.

Bethesda Hospital Society

FROM THE TIME WHEN Steinbach was settled in 1874 until the year 1929, the sick were cared for in the homes. Babies were delivered by midwives. Only the severely ill were taken to Winnipeg for hospitalization. The need for a local hospital was keenly felt. In 1929 Mr. A. Vogt opened a privately-owned 9-bed hospital. His sister, Miss Maria Vogt, who is at present the matron of Bethania — a home for invalids north of Winnipeg — was placed in charge of it.

Until 1931 it was mainly a maternity center. In that year an operating room added to the efficiency and serviceability of the hospital. This also gave Bethesda the advantage of a general hospital license — the

Bethesda Hospital

first institution of its size in Manitoba to be thus designated. The daily fee was as high as $1.50 per patient.

Meanwhile a group of local men organized what was called the "Mennonite Society for Aid of the Sick." Their purpose and goal was to study the affairs of the hospital, and to create an interest in and a sense of responsibility among the people towards the need for a community hospital. They started the ball rolling with much faith and very little money. The adoption of the "Free Donation Plan" instilled into the people's hearts and minds the possibility of realization of the project by donating whatever material, time and money that they might have. Their dreams came true when in 1936 the framework of the hospital was erected.

On January 1, 1937 the new hospital, named Bethesda, was opened for a service of mercy, with a staff of two registered nurses; Miss Linda Reimer — now a missionary nurse in Panama — and Miss Vogt; one laundress and one cook. The hospital boasted one operating room, one delivery room, a small x-ray unit and beds for 23 patients. Sleeping quarters for the staff were in the basement. Daily working hours often exceeded 12 to 15 hours. The early doctors who did much to guide the hospital through its pioneer struggles were: Dr. R. Whetter, Dr. A. Henderson and Dr. M. Hodgson.

The people of the community realized the advantages of a modern local hospital. Soon the wards were filled to capacity. In 1946, 297 babies were born and 859 patients admitted. The staff had increased to 22 people. The hospital board members realized that the hospital facilities were inadequate. The future looked brighter now so, with new courage and ambition, they embarked on a $100,000 expansion plan.

On October 15, 1949, the new wing was opened. Now the hospital provided accommodation for 42 adult patients, two operating rooms, better and larger x-ray facilities, a better equipped laboratory, a cheerful children's ward, and a 15-bassinette nursery. The public health department moved into a 6-room suite in the new wing. Thus another milestone had been reached.

In 1953, a modern 32-bed nurses' residence was opened to accommodate the staff comfortably. For further convenience, a tunnel was made to connect the residence and the hospital.

Included in the history of Bethesda is the tireless work done by the hospital Ladies Aid. From the day the doors were opened, they have supplied the hospital with linen and bedclothing. A large portion of canned goods is supplied by various members of the group. Layettes for needy mothers are furnished. Once every week the members come in to do the mending. Were it not for the willing work of the Ladies Aid the hospital would have experienced difficult days.

Looking back over the years to the early beginning, and comparing it with the present set-up, we can truly say that those who have put their shoulders to the wheel, have not done it in vain.

MARY HIEBERT
Matron, Bethesda Hospital

In The Good Old Days

(The Canadian Nurse — APRIL 1917)

The graduate nurse seems to be the only individual who is trained to do one thing but is expected, once she possesses a hospital diploma, to do anything and everything a community demands and to do it cheerfully and well!

* * *

Nurses are accustomed to hearing the old assertion that nursing as a profession is young, but as an art is as old as the hills. They are apt to forget that the first nurses were friendly visitors and almoners and that we have had to make several departments of what was once one vocation. Thus dietitians, social workers, and other specialists are essential because our far more complex civilization makes it impossible for one worker to handle well all the problems that such a civilization entails.

* * *

One or more decayed teeth, with constant infection, so impairs the vitality of a child that physical and intellectual development is impossible. The resultant deformity of the jaw interferes with the proper development and function of the brain.

* * *

The Windsor Hotel, Montreal, will be the scene of the 1917 convention. Room rates: Single room, with bath, $3.00; without bath, $2.00 per day. Double room with bath, $4.00 per day.

RESEARCH

Sèvres 1956

F. Lillian Campion *and* Rita MacIsaac

Thirty-four people from twenty countries meeting, many for the first time, in a setting reminiscent of the era of Louis XV, in a residence in which once lived Mme Pompadour — and this was November 11th, 1956, in Sèvres, France.

The occasion — the first international Conference on the Planning of Nursing Studies.

The place — the Centre International d'Etudes Pédagogiques.

The people — nurses from all over the world — from many different fields of nursing but all with a common purpose — to learn how to improve nursing service through research.

This conference was organized by the Florence Nightingale International Foundation in association with the International Council of Nurses. Since 1950 hopes for this conference had been nurtured, that now had become a reality. The F.N.I.F. Committee, under the Chairmanship of Mrs. Louise McManus, Director, Division of Nursing Education, Teachers' College, Columbia University, had spent many months and years searching for ways to realize this hope — searching for money, staff, participants and place. Eventually the difficulties which arise in such a search were overcome.

Funds were provided by the Rockefeller Foundation. Miss Margaret Arnstein, Chief, Division of Nursing Resources, Public Health Service, U.S. Department of Health, Education and Welfare, agreed to act as conference leader with Professor Fraser Brockington, School of Preventive Medicine, Manchester University, England; Professor Bernard G. Greenburg, Department of Biostatistics, School of Public Health, University of North Carolina; Mme Ariane Levy-Schoen, Attachee au Laboratoire de Psychologie Sociale, Sorbonne, as members of the conference staff. National nurses' associations each sent one or two representatives. France was the country chosen and an internationally known educational centre was the site of the conference.

Some 10 miles from Paris, Sèvres is the home of the famous Sèvres porcelain, in fact the Centre was the original site of this manufacture. The road from Paris through Sèvres leads to Versailles and it was along this path that the mob marched to the Palace at the beginning of the French revolution.

While history surrounds the Centre, the modernday need for the promotion of international understanding is being fostered here where many international study groups are held.

The two-week conference began on November 12. Miss Yvonne Hentsch, Director, Nursing Bureau, League of Red Cross Societies, who is the present Chairman of the F.N.I.F. Committee, presided at the opening session.

It was a work conference with the mornings devoted to lectures and panel discussions and the afternoons mainly to work in small groups. Its purpose was threefold — "to promote research, to find the best methods for research, and to give leadership to research." It was realized that it would be impossible in a two-week conference to

Miss Campion is Secretary of Nursing Service for the Canadian Nurses' Association. Miss MacIsaac is Assistant Secretary at CNA National Office.

prepare nurses to undertake research.

It was a privilege to take part in this conference and by means of the following material we would like to share with all Canadian nurses the knowledge we acquired at Sèvres.

What is Research?

A burning yearning for learning — not earning.

Research has been defined as "a critical and exhaustive investigation or experimentation having for its aim the discovery of new facts and their correct interpretation, the revision of accepted conclusions, theories or laws in the light of newly discovered facts, or the practical applications of such new or revised conclusions."

Special qualities and abilities are necessary for such scientific research. However, research may be considered in a broader sense. A consciousness of one's profession imposes the need to ask questions, to seek answers and to make improvements. All research should be designed to answer one or more questions, and may be more simply defined as *"a planned systematic attempt to answer a question."*

Some problems may be solved by administrative action, others by research. The complexity of the problem or question will determine the type of research needed, but the scope of the research project should not be larger than the need.

The hallmark of true research is meticulous planning, scrupulous attention to detail, objectivity and critical analysis.

Research in Nursing

A profession must assume the responsibilty for the improvement of its practice. Nursing must be conscious of the changing needs of society and of the responsibilities imposed upon the profession to seek ways to meet these needs. It must decide what problems can be answered by research studies. Only a few will direct and plan research projects, many will participate, all need to know something of the research process. Nurses must be able to formulate the questions which are answerable through research.

What are these problems? To date nursing research has dealt mainly with functions, shortages and needs. These studies are important as the groundwork for the improvement of nursing service, but it is important now to study nursing practice itself and what it does for patients.

There is need for research into the human relationships between the nurse and patient. The psychology of the patient has scarcely been explored. How does he react to illness and to isolation from his usual environment? How can the nurse be helped to recognize and modify his reactions?

The psychology of the nurse is of utmost importance as she frequently works under stress and tension. When does she reach the point of fatigue? How can she give the best service possible with the least stress?

The relationship between the nurse and her co-workers is important in patient care. This requires team work, and the recognition of the antagonisms and attractions which can modify the pattern of a group.

The scope of nursing has broadened to include health education. The nurse needs to understand the psychology of teaching healthy people. Principles of learning and teaching should be introduced to the student nurse in her basic preparation. Research is needed in the nursing curriculum. We can learn much from the research which is being carried out in the general educational field.

It is important that all professional workers be exposed to research methods so that they may develop powers of observation and a critical attitude, know approved sources of references, and be able to contribute to the accumulation of research information.

Nursing should today be establishing basic tools for evaluation and developing criteria for judging the quality of nursing care. The small experiments which are being done in many places should be published. These will add to the determination of criteria and will help in building up a body of research.

How to Plan a Research Project

1. *The Search for Enlightment — Reflective Thinking:*

(a) *Definition of purpose* — Write the question to be answered in definite form, submit it to others for their consideration. Consider whether the project is necessary, possible, topical, too ambitious, or ambiguous.
(b) *Intellectual synthesis* — First study the available literature relating to the problem, then discuss the project with colleagues and with experts in special fields, such as statisticians. It would be of value to obtain the assistance of a research centre, or university.

The procedures should be set out under a formal agenda which includes the title, problem, objectives, methods and techniques. A skeleton report should be drafted which will give the report title, chapter headings, some indication of what the findings are expected to bring out, and the tables on which the report, will be based.
2. *The Search for Tools:* Decide on the type of study, the nature of the information required, how to collect analyzable data, and the population to be studied.
3. *The Search for Money:* It is important to clearly state what is proposed and show that it is practical.
(a) *Pilot project* — This is very important at this stage of the planning, as are all pre-tests. It may be done without great expense and with our own resources. From this pilot project, it should be possible to estimate the cost of the entire study.
(b) *Costing*
(i) Director — this may be a full or part-time position.
(ii) Agents — for inquiry, questionnaire, observation, or interviews, which will determine how much time will be involved and how much one person can be allotted to do.
(iii) Staff — travelling expenses.
(iv) Clerical or administrative staff.
(c) Approach should be made to Government departments, public trusts, business firms, etc. While these tend to have some strings attached, this should not be of concern unless it interferes with the integrity of the work.
4. *The Search for Public Support:* The sympathy and understanding of the people concerned should be sought, through newspaper, T.V., radio and by a briefing letter. Special consideration should be given to voluntary organizations and governing bodies such as hospital boards, town councils. Newspapermen can be most helpful, if time is taken to explain the project and gain their interest and understanding.
5. *The Search for Staff and Organization:* The director of the project should be carefully selected. The number and types of other workers will depend on the study to be conducted. Sound briefing should achieve complete understanding of the study planned, how it is to be conducted and should clarify any difficulties and misunderstandings which may exist.

How to Write a Research Report

Title — Should be concise and arresting.
Preface — Should give the nature of the inquiry from which the project stemmed.
Chapters — Should be under colorful and explicit chapter headings which will describe the contents. The number of chapters will vary according to the extent of material contained in the report.
Conclusions, summary and recommendations — It is arresting and quite acceptable to put the conclusions at the beginning of the report.
Bibliography and references — Should be written in an acceptable form.
Appendices — It should be clearly determined what goes into the body of the report and what goes into the appendices; this is a matter of judgment. The report should be kept readable by avoiding congestion. Only tables which are discussed should appear in the body of the report.

All relevant material should be published as it may be of significance to others at a later date. The independent observer should be able to know exactly what has been done. Previous investigation undertaken in the field should be placed in the preface or first chapter. A statement as to whether and how further research should be undertaken is of value. All abstract material should be reduced to clear, concise statements.

Types of Research Studies

1. *Observational or descriptive sur-*

vey: This is a series of investigations in which an attempt is made to describe a response pattern without any effort to explain why it occurs or to analyze its characteristics. The response pattern can be described in most instances by an average.

Examples — a sample survey might be conducted to measure income, opinions, attitudes, food habits, kinds and amount of hospital insurance in force, patterns of medical care obtained, the quality of medical or hospital care, kinds of positions accepted by graduates of a school of nursing, number of hours of nursing care per patient, and others.

The procedure by which a segment (or sample) of the entire universe (or target population) is selected is a most critical element in this type of research and carries more influence here than in any of the succeeding research endeavors.

2. *Analytical survey (diagnostic):* In some investigations, a simple description of the findings is the first step, to be followed by an analysis of reasons why a pattern has assumed certain forms of distribution. Most studies in this type of research are retrospective, including a large proportion of epidemiological investigations. Caution must be exercised not to ascribe causation to what might simply be association.

For example, an investigation might be made, on a retrospective basis, among cases occuring in an epidemic and inferences drawn about the source of the epidemic from the distributional pattern. *Or,* a growth study may be made attempting to relate observed differences to diet and other environmental influences that have already transpired.

The problems of sampling procedure are sometimes important here but not as frequently as is the case with descriptive studies.

If the research is retrospective and casual relationships are under investigation, the hypotheses can be strengthened in such a way that they are difficult to prove if only association is involved.

Examples of this technique are found in lung cancer-smoking studies and antigen-inoculation-poliomyelitis studies.

3. *Development or refinement of measuring tools:* This is often referred to as pure or fundamental research. The development of an instrument, whether a questionnaire, battery of tests, or a physical implement operating on mechanical, electrical, chemical, or engineering principles is usually the first step in a continuing series of research projects. This is particularly true today in the social sciences, including public health. The sampling procedure in selecting test subjects for experimentation in this phase is an unimportant detail unless there is an interaction between the measuring instrument and different groups of people.

For example, a thermometer will work equally well on any human subject but a serological test for syphilis may only work well on certain segments of the population, or, a battery of psychological testing devices may have to be altered for many ethnic and cultural groups in the population.

4. *Experimental or comparative study:* This research is founded upon the testing of an hypothesis or estimation of a comparative nature such as in the relative potency of two compounds in a bio-assay. It is usually on a prospective or progressive basis with respect to time. The most important distinguishing characteristic of this type of research is, however, the fact that assignment to the experimental units must be under the complete control of the investigator. This fact alone may differentiate it from an analytical survey where nature has allocated the subjects to differing groups or treatments.

For example, one might be interested in determining if a program is effective over no program at all, or how effective it is in terms of a quantitative amount, or whether it is better than some other program or programs.

The latter situation is referred to as "spotting the winner" and is the only type of research, under this category, which requires no controls since the other programs being compared provide a type of internal control. Controls are good insurance, nevertheless, in the event that no differences appear among the programs under comparison.

This research usually requires close attention to sampling procedure. Each individual study requires clear-cut investigation to see whether controls

and sampling problems are important.

Sampling

A sample is a segment of a larger group which is examined in detail in order to learn one or more characteristics about the latter. The larger group is referred to as the parent population, target population, or sometimes population alone.

The sample must be adequate. Factors of adequacy involve quantity and quality.

(a) *Quantity:* The size of the sample must be sufficient to accomplish the purpose but should not be more than necessary or it becomes wasteful. The size is determined by:

(i) Variability of the attribute or characteristic in the target population which it is desired to describe or generalize about from the sample.

(ii) the precision that is desired in describing this attribute in the target population.

(iii) the size of the target population.

(b) *Quality:* The sample must be representative of the target population if inferences made from one are to be applicable to the other. All of the approved or scientific methods involve a random element in the final selection.

Epilogue

The foregoing covers only part of the lecture content. It is expected that the papers presented will be available and it may be that these could be published at a later date.

Five groups assembled each afternoon with one of the conference staff as leader. A patient care study which had been carried out in the United States was studied. The steps involved in the design of a questionnaire, sampling techniques and the methods of processing data were discussed in detail.

Each group was truly international. Representatives of the Netherlands, Austria, Sweden, Denmark, Belgium, France, Norway and Canada met in one group for instance. The participants' experience in research varied from those who were actually participating in research projects to those who had had no experience whatsoever. It was interesting to observe the "group togetherness" which was developed over the two week period. We learned from the leader and from each other. The similarity of problems in nursing which require study was most noticeable among the countries represented.

One could not write about this conference without referring to the outstanding guidance of Miss Margaret Arnstein as director, and of the other members of the conference staff.

The organization of the conference by the F.N.I.F. staff undoubtedly made it the success which it was. To the National Association of Trained Nurses of France who, with gracious hospitality did all in their power to make our stay pleasant, we are indebted.

Finally, to those who made it possible for us to attend — to the Executive Committee of the Canadian Nurses' Association, and to the Canadian Red Cross Society which generously provided the funds for a second member of the C.N.A. staff to participate, our most sincere thanks.

Résumé

La première conférence internationale sur l'organisation des programmes d'études pour les infirmières a eu lieu à Sèvres, France, le 11 novembre 1956. Vingt pays y étaient représentés par des infirmières appartenant aux différents domaines de la profession du nursing et venues pour apprendre comment la recherche peut contribuer à l'amélioration du service du nursing. Cette conférence, organisée sous les auspices de la Fondation Internationale Florence Nightingale et le Conseil International des Infirmières fut financée par la Fondation Rockefeller.

L'on commença d'abord par définir la recherche puis les qualités et l'habileté nécessaires aux personnes qui se livrent à la recherche scientifique.

La recherche doit avoir pour fin de répondre à une question, à un problème; elle peut être définie: "un plan systématique proposé pour répondre à une question."

La valeur de la recherche est en raison de la préparation apportée, de l'attention accordée aux détails, de l'objectivité et de l'analyse critique.

Toute profession a le devoir d'améliorer sa pratique.

Les changements que subit constamment la société créent de nouveaux besoins aux-

quels les infirmières doivent être en mesure de satisfaire.

Quels sont les problèmes à étudier?

La recherche semble toute indiquée dans les questions: relations humaines — relation infirmière-malade — la psychologie du malade, ses réactions devant la maladie, l'isolement de son milieu — l'aide que peut lui apporter l'infirmière. La psychologie de l'infirmière qui souvent travaille inquiète et sous tension, dans quelles conditions peut-elle donner le meilleur rendement — rapports entre l'infirmière et les autres membres de l'équipe sanitaire.

Le travail de l'infirmière comporte l'enseignement de la santé, elle doit donc connaitre la psychologie des personnes en santé, les principes de la pédagogie.

La conférence a poursuivi son travail sur les moyens de faire la recherche:

Préparation: importance de définir les buts, de recueillir tous les renseignements disponibles sur le sujet.

Forme à donner à la recherche.

Trouver les fonds nécessaires et exposer clairement le but et le côté pratique de la recherche proposée.

Informer le public afin d'avoir sa sympathie, de s'assurer sa compréhension et sa collaboration.

Organiser le personnel — choix du directeur et des autres membres.

Comment rédiger les rapports — titre général, rubriques explicites des chapitres — conclusion, résumé et recommandations — bibliographie et autres sources de renseignement, appendices, etc.

Différentes formes que peut prendre la recherche: description d'une observation — analyse — expérience, permettant de révéler la valeur du matériel et des instruments employés. Comparaison, à la suite d'expériences de différents groupes.

Comme démonstration pratique, une étude faite aux Etats-Unis et portant sur le plan des soins à un malade, fut analysé par les infirmières partagées en cinq groupes, et fut étudié et discuté dans tous les détails.

Medical Records Department

MARJORIE GRANT

IN THAT MOST rapidly progressing and changing profession — medicine — the medical records department which truly serves its hospital and community obligates itself to keep abreast of trends.

The modernized and well-equipped records department at Grace Hospital, strives to accomplish this service. In one office is contained everything pertaining to medical records. This office is advantageously situated near the hospital entrance, directly adjacent to the doctors' lounge. Such locale is a major factor from the standpoint of convenience to both physicians and records' staff. Large glass doors, opening into the department, afford a ready view of those doctors entering the building. The over-all decor is moonmist grey and Berkshire green — a color scheme widely accepted in modern office design.

Especially constructed cupboards for charts and case summaries occupy every wall space. Built-in cubicles house: Microfilm equipment (optimum in space-saving); tapewriters for medical dictation, and units for transcription; Ediphone Televoice system hooked up with operating rooms, for surgical dictation. Such valuable equipment is, of course, locked at night. However, there is an over-all plan for 24-hour accessibility, and doctors may review complete charts at any time convenient to them.

A section is set aside for doctors wishing to write up charts. Near at hand are special compartments for their incomplete charts and for special reports, such as autopsies, pathological reports, etc.

Such convenience, additional space and modern equipment results in more speedy processing of medical records. Thus, there is more time to evaluate work, and delve into those interesting points which will further assist the physician.

From the standpoint of the practitioner, he has more and better faci-

Mrs. Grant is in charge of the Records Department at Grace Hospital, Windsor, Ont.

lities, lessening (it is hoped!) the "bugbear" of charts. An interested staff increases his confidence in the department, and indirectly stimulates concern for better records.

The physician will readily admit the value of *good* records when available to him for diagnosis and treatment. To recognize that he does have problems in the prompt and adequate completion of his charts — and to meet him half-way in the solution of such problems — really pays off in a department such as this.

To summarize, the entire program elevates the standards of records in our hospital, contributing to the welfare of the patient, the practice of better medicine, and the health of the community.

Cancer of the Cervix

N. Rieger

Mrs. Ross was admitted to hospital with a history of intermittent bleeding. Intermenstrual bleeding is noted most frequently in women approaching the menopause. It is especially significant as an indication of serious disease — specifically carcinoma of the cervix.

The cervix is the most common site for malignant disease in the female reproductive tract. Diagnosis is made with the aid of pelvic examination, cervical smears and biopsy. In untreated patients the disease is fatal in one to three years. Cure may be effected in early cases by radical removal of the uterus or by destruction of the growth with radium therapy.

Social History

Mrs. Ross is 28 years of age. Her husband is a member of the Royal Canadian Air Force. They have no children.

Mrs. Ross lives with her mother and was working as a waitress prior to her present illness. She has also had experience as a switchboard operator and plans to apply for this type of work as soon as her condition permits. Although her husband's income is quite adequate, Mrs. Ross prefers to work. As soon as her husband is permanently stationed, they plan to buy their own home and adopt a child.

Emotionally, Mrs. Ross seems very well-balanced in spite of the fact that her mother upsets her frequently. Her father died of cancer several years ago and her mother blames Mrs. Ross for having developed her present illness. Her husband has been a source of strength to Mrs. Ross. He discussed his wife's illness with her mother which helped to improve that situation greatly. Although still very worried and depressed at times over the possible outcome of her illness, Mrs. Ross does not have a feeling of complete hopelessness.

Medical History

Mrs. Ross' past history includes a tonsillectomy, and an attack of pleurisy. She had a bout of hematuria several years ago, and later developed jaundice. Although she very much wanted children of her own, Mrs. Ross has not been successful. One pregnancy terminated in miscarriage and cauterization of the cervix has been necessary on four occasions.

In describing the onset of her present illness, Mrs. Ross stated that she has had intermenstrual bleeding over a period of several months. Her last normal menstrual period occurred about seven weeks prior to her admission. She began bleeding again about three weeks after cessation of menstruation and this has continued irregularly ever since — sometimes only a slight amount and other times profusely. There was a small amount of dark

Miss Rieger was an intermediate student at Misericordia Hospital, Winnipeg, when she carried out this study.

red bleeding on admission but her general condition seemed good.

Three days after admission a pelvic examination was performed and the doctor thought that a palpable tumor was present on the cervix. A biopsy was performed and the following report received.

> The presence of a rounded swelling on the anterior lip (of the cervix) was confirmed . . . It appeared to be very vascular. Blood was oozing from the surface. It was removed by performing a Bonney's repair of the cervix. Dilatation and curettage were done. Curettage of the uterus revealed no cause for bleeding. It is thought that the symptoms arise from a cervical tumor.

The pathology department reported that an epidermoid carcinoma of the anterior lip of the cervix was present. A section of the posterior lip showed erosive inflammation but no malignancy.

A few days later, under pentothal, cyclopropane and nitrous oxide anesthesia, a radical hysterectomy was performed.

Preoperative Nursing Care

The amount of vaginal bleeding was carefully noted and charted preoperatively. As preparation for the performance of the biopsy, shaving of the external genitalia was done and a soap suds enema given. Immediately prior to going to the operating room, Mrs. Ross was catheterized and the catheter was left in position. Vital signs were noted and charted. Mrs. Ross was not allowed food or fluid for several hours in advance.

She received a hypodermic injection of demerol and hyoscine a short time before operation. This helped to calm her and assist in better anesthesia.

Mrs. Ross' preparation for hysterectomy was very similar to that for biopsy. A dettol douche was given to her on the evening before and morning of operation. Catheterization was performed and the catheter again left in position. Cross-matching and blood-typing were done since it was anticipated that Mrs. Ross would require transfusion. The preoperative hypodermic injection contained morphine gr. 1/6 and atropine gr. 1/150. This aided in alleviating nervousness and in reducing mucous membrane secretion — necessary for safe and satisfactory general anesthesia.

Postoperative Nursing Care

Following her biopsy, Mrs. Ross remained in bed for only a few hours. She was allowed up on the evening of her operative day. Deep breathing was encouraged to ensure adequate lung expansion following anesthesia. A normal diet was allowed as soon as Mrs. Ross could tolerate it. The vaginal packing was removed 12 hours after insertion and Mrs. Ross was checked carefully for bleeding. Perineal care was carried out after each voiding to help reduce the possibility of infection. A lamp to the perineum at intervals gave Mrs. Ross considerable comfort.

Following hysterectomy, Mrs. Ross required the intensified nursing care associated with major surgery. On return from the operating room, she was receiving blood and 1000 cc. of 5% travert in distilled water, intravenously. This was of great assistance in maintaining her systolic blood pressure within normal limits. Deep breathing was encouraged to help avoid pulmonary congestion. The in-dwelling urinary bladder catheter was drained at regular intervals and an accurate record of intake and output kept.

Mrs. Ross was given a fluid diet until a full diet was tolerated.

Her dressings were changed as necessary and the wound cleansed with hydrogen peroxide and alcohol. The catheter and vaginal packing were removed two days postoperatively and the drain in the abdominal wound was removed six days after operation.

To avoid circulatory complications, Mrs. Ross was encouraged to get out of bed as soon as possible — her second postoperative day. In an effort to relieve uncomfortable gas pains, she was given a 2-4-6 enema.

Removal of the uterus in the premenopausal woman is upsetting to the endocrine balance in the body. This is manifested both physically and mentally. It helped to explain the periods of depression and bouts of crying which Mrs. Ross had. She needed encouragement and reassurance.

Medications

Mrs. Ross received a number of medications in addition to her preoperative injections.

Curare — was used to increase the effectiveness of the general anesthesia since it produces very complete muscle relaxation.

Penicillin — was given prophylactically to reduce the possibility of postoperative infection.

Perihemin — an iron, B_{12} and folic acid combination — was useful in overcoming the tendency towards anemia which Mrs. Ross showed as a result of long-term blood loss.

Mepilin — a hormonal preparation — helped to overcome the unpleasant effects of premature menopausal symptoms.

Conclusion

Mrs. Ross' convalescence was uneventful and she was discharged home less than a month after operation. Unfortunately her doctor felt considerable pessimism regarding her life expectancy. She was advised to continue having frequent medical examinations. Her doctor was interested in assisting with the adoption of a child to keep Mrs. Ross occupied mentally and physically.

Cancer and Modern Living

Is our modern way of living causing an increase in cancer?

In the first place, is there an increase in cancer deaths? According to the Canadian Cancer Society, the cancer death rate has risen slowly but steadily over the years. Last year it was 142 per 100,000 of population for men and 123 for women. But we must take into consideration that cancer is to a large extent a disease of the aged and as fewer people die of pneumonia, tuberculosis and other diseases, more will live to die of heart disease and cancer.

At the same time more cancers are being cured than ever before. Cancers of the skin, mouth and other accessible sites are often successfully treated by radiation or surgery or both, especially if treatment is begun early.

On the other hand, the death rate from lung cancer has increased by 100 per cent over the past ten years. Last year more than 1500 Canadian males and more than 300 females died from lung cancer.

There is no conclusive proof that this is due to cigarette smoking. Many investigators believe that the accumulation of carbon monoxide from car exhausts, the smoke from trains and factories, the oil fumes from countless chimneys, the tar from the roads and other air-polluting substances are all contributing to lung cancer.

It is known that all of these contain cancer-causing chemicals called carcinogens. There are over 400 of these carcinogens and they turn up in such unlikely places as food dyes, preservatives, cosmetics, coal tar, cleaning and polishing agents, sanitary goods, and insecticides.

From this list one might get the idea that the best way to avoid cancer would be to quit eating, drinking, and breathing. I would, too, but unfortunately we can't do that. There are, however, other things that can be done.

The control of air pollution is advocated by many scientists as the best means of controlling lung cancer. This task has been tackled successfully by some American communities and is being studied extensively in Canada. Also, much more attention being paid to the chemicals that we add to food and elaborate "screening" tests are applied to most before they are used.

Most important of all are the precautions that each one of us can take against cancer. As stated earlier, many common types of cancer can be successfully treated if the growth is detected early. For this reason the Canadian Cancer Society advocates that each one of us should know the cancer danger signals and, what is more important, have a medical check-up when one of them is suspected.

Cancer Society material can be obtained from any unit of the Canadian Cancer Society. Today many industries are taking advantage of the Society's Indus-

trial Education Program. They are setting up in-plant committees of the Society that take over the responsibilities for making available pamphlets, posters, films and speakers. They arrange for nurses to visit the plant and give personal interviews to those requiring them.

Of course, the only complete answer to the cancer problem lies in research. When scientists discover the cause of cancer they will likely be able to develop better overall cures and even means of prevention.

Most of the money raised during the Canadian Cancer Society's annual campaign for funds is used to support an expanding research program in this country. —CANADIAN CANCER SOCIETY

The Little Red Door

B. CALCOTT

IN 1931 CANCER was recognized as a growing health hazard in Canada. As a first step in dealing with this problem, a professional committee was formed, designated the Cancer Medical Association. The members of this committee spent six years in intensive study of the situation and of the means by which it might be controlled.

Early recognition of symptoms and prompt medical care were vital factors in successful treatment. The insidious nature of cancer and the tendency to overlook or ignore the first signs and symptoms made education of the general public a necessity. Lay volunteers of the Association were asked to spread information about cancer among their friends and neighbors.

In 1937 the Canadian Cancer Society was formed. The program of public education was extended through the use of a variety of informational materials. All material was first approved by a medical board before reaching the public.

In 1947, with cancer incidence still on the increase, information centres were organized across Canada, staffed by graduate nurses. From these centres pamphlets, films and literature are distributed to the public. The "Little Red Door" or cancer information centres stand ready to lend a hand to Canadians who have developed this condition, helping with the problems subsequent to it. Citizens are welcome to bring their medical and financial problems. The "Little Red Door" does not undertake to pay hospital bills but can direct such needs through the proper channels. No attempt is made to pay doctors' bills but financial assistance is given for actual treatment of cancer.

Non-ambulatory patients have transportation to and from hospitals or treatment centres provided for purposes of x-ray therapy or other treatment. Dressings are provided and a limited amount of nursing care. For those patients requiring hypodermic injections, the graduate nurse staff will provide assistance as required. The centres will supply drugs when the expense is beyond the financial means of the patient.

The Door is always open for any one wishing the services provided by these centres. Help is forthcoming to all who wish it but is forced upon no one. All records are confidential.

Canadians have come to associate the month of April with the annual drive for funds for the work of the Cancer Society. The three-fold aim of the Society is research, education and welfare. To the extent that we support this drive, will the Cancer Society and the "Little Red Door" be able to maintain and extend their services. Have you forgotten to make your personal donation?

Miss Calcott, who is on the staff of the Sarnia General Hospital, contributed this information as part of a nursing clinic.

Often when a person starts to rest on his laurels he discovers they are poison ivy.

The Shape of Things to Come

FRANCES MCQUARRIE

TEN THOUSAND dollars to start! That is the good news from the Pilot Project on Evaluation of Schools of Nursing. The CNA Executive Committee voted this amount — approximately one quarter of the total amount that will be needed — to the project at its meeting in Ottawa the middle of February. The special Committee on the Pilot Project met immediately afterwards to prepare a timetable for the important steps preliminary to the actual evaluation of schools of nursing.

Applications for the directorship are earnestly sought from all those who are in a position to undertake this piece of work. As the results of the project may influence the whole picture of nursing in Canada, it is hoped that a Canadian nurse can be found who is experienced in both nursing service and nursing education and whose philosophy of nursing is flexible and dynamic. The selection of the director will be made by the Sub-Committee of the Executive Committee, in keeping with selection practices for all professional appointees to National Office. When the appointment is made the director will have a period of orientation to National Office and then proceed to New York for four months study of accreditation practices with the National League for Nursing. It is estimated that the entire project will take two years.

In the meantime all schools of nursing that are willing to participate in the project have been asked to inform their provincial nurses' association and to supply a brief description of their school and educational program. This information is to be received in National Office from the provincial associations by April 15, 1957 and the selection of not less than 20 schools is to be made by the Special Committee on the Pilot Project by April 30. It is hoped that many schools will volunteer so that the selection will represent a cross-section of all French and English diploma programs in basic nursing education in Canada. When the schools are chosen, each will be asked to outline detailed information about its educational program, faculty, student body, hospitals in which the students are assigned for clinical experience, method of financing and many other items. Although this will, without doubt, entail a considerable amount of work on the part of the entire faculty, the value to the participating schools in the clarification of its policies and practices will be many times greater.

At the same time, provincial nurses' associations are being asked to secure data on nurses who would be willing to assist the director as regional evaluators. The number of regional evaluators chosen by the Special Committee on the Pilot Project will depend on the location of the schools of nursing taking part, one evaluator, perhaps, acting in two provinces. This selection will be made also by April 30. Just prior to the actual commencement of the evaluation of the schools the regional appointees will be brought together for a week's intensive orientation so that they will be prepared to participate actively with the director in the school visits.

The Special Committee on the Pilot Project is now directly responsible to the CNA Executive Committee. Sister Denise Lefebvre has consented to continue giving us her assistance by assuming the chairmanship. The membership of the Committee remains the same as for the Task Committee on Accreditation of the Committee on Nursing Education with the addition of the chairmen of the Committees on Nursing Education and Finance and the immediate Past President. The Canadian Nurses' Association is most grateful that these members, who occupy full-time positions of responsibility in their own areas, are willing to give their time and energy to this important project.

Miss McQuarrie is Nursing Education Secretary with the Canadian Nurses' Association.

UN GRAND PROJET PREND CORPS

FRANCES MCQUARRIE

Dix mille dollars pour commencer! Voilà la bonne nouvelle au sujet de l'Etude de Contrôle proposée pour l'Evaluation des Ecoles d'Infirmières. Le Conseil Exécutif de l'A.I.C. a voté cette somme — environ un quart de la somme totale nécessaire pour poursuivre l'Etude — lors d'une récente assemblée tenue à Ottawa. La Commission spéciale chargée du Projet s'est réunie pour établir un schéma des étapes préliminaires qu'il importe d'entreprendre avant d'aborder l'évaluation proprement dite des écoles d'infirmières.

On cherche maintenant une directrice pour assumer la responsabilité de ce projet et l'A.I.C. invite toutes celles qui seraient disponibles pour cette tâche à poser leur candidature. Comme ce projet aura sans doute des résultats qui influenceront toute l'histoire du nursing au Canada, nous espérons trouver une infirmière canadienne ayant de l'expérience dans les deux domaines du service et de l'éducation en nursing et dont la philosophie est à la fois souple et dynamique. La directrice sera choisie par le Sous-Comité du Conseil Exécutif, qui agira conformément aux principes qui régissent le choix de tout le personnel professionnel au Bureau national. Une fois nommée, la Directrice fera un stage au Bureau national pour y recevoir des directives et se mettre au courant des travaux préliminaires accomplis, après quoi elle ira passer quatre mois à New York pour étudier les pratiques d'accréditation de la Ligue Nationale du Nursing. On estime que le projet complet durera deux ans.

Entre temps toutes les écoles d'infirmières désireuses de participer au projet seront priées d'en informer leur association provinciale d'infirmières et de fournir une brève description de leur école et de leur programme. Ces renseignements devront parvenir au Bureau national avant le 15 avril 1957, afin de permettre à la Commission spéciale chargée du Projet de choisir au moins vingt écoles avant le 30 avril. Nous espérons recevoir un grand nombre d'inscriptions volontaires à ce projet afin que les écoles choisies représentent véritablement le type moyen de tous les programmes de base au Canada, tant de langue française que de langue anglaise qui aboutissent à un diplôme. Lorsque les écoles auront été choisies, chacune sera priée de fournir des renseignements détaillés sur son programme d'enseignement, sa faculté, son corps étudiant, les hôpitaux où ses étudiantes reçoivent leur expérience clinique, son mode de financement et maints autres items. La préparation d'un tel rapport exigera sans doute de la part de la faculté tout entière une somme considérable de travail; par contre, leurs efforts seront plusieurs fois récompensés par les avantages que retirera l'école dont la politique et les pratiques auront été ainsi scrutées et clarifiées.

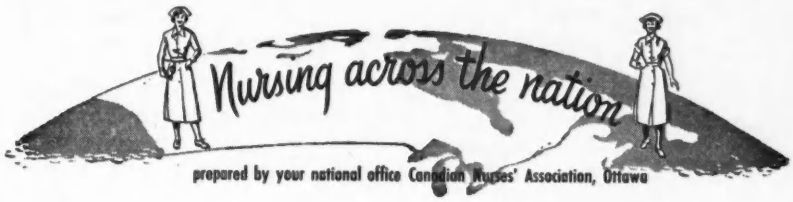
Simultanément les associations provinciales d'infirmières s'occuperont de recueillir des renseignements sur un certain nombre d'infirmières qui seraient intéressées à seconder la Directrice, en qualité d'évaluatrices régionales. Le nombre d'évaluatrices régionales que choisira la Commission spéciale dépendra des endroits où seront situées les écoles participant au projet; il est possible qu'une évaluatrice soit chargée de deux provinces. Le choix des évaluatrices se fera également avant le 30 avril. Juste avant que le programme d'évaluation commence pour de bon, les enquêteuses régionales se réuniront pour une semaine d'orientation intense afin d'être en mesure de participer activement aux visites des écoles avec la Directrice.

La Commission spéciale chargée du Projet d'Etude de Contrôle relève maintenant directement du Conseil Exécutif de l'A.I.C. Soeur Denise Lefebvre a bien voulu accepter d'en demeurer la Présidente. Les membres de la Commission sont les mêmes que celles de la Commission spéciale d'Accréditation du Comité de l'Education en Nursing plus les convocatrices du Comité de l'Education en Nursing et du Comité des Finances et la dernière Présidente sortie de charge. L'Association des Infirmières Canadiennes exprime sa reconnaissance à toutes ces personnes qui, en dépit de leurs obligations professionnelles parfois très absorbantes, réussissent à consacrer avec tant de générosité leur temps et leur énergie à cet important projet.

Notre cœur s'enfle tellement que nous regardons tous les autres comme étant d'un ordre inférieur à nous. — Bossuet

* * *

Pour que l'on vous obéisse, obéissez aux lois. — Voltaire



Our National Representatives

Ottawa and National Office plays hostess every February to the nursing leaders of Canada, when the CNA Executive Committee meets at the Chateau Laurier for three days.

Your province was represented by the president and executive secretary of your provincial registered nurses' association Three religious sisters representing the Western, Ontario, Quebec and Maritime regions were in attendance. National committee chairmen from Halifax, Fredericton, Montreal and Toronto; the chairman of the Editorial Board and the editor of the *Journal* are all members of the Executive. Presiding at the sessions was Miss Trenna Hunter of Vancouver, CNA President.

From the Folio

Prior to each general or executive meeting, reports are forwarded to National Office for compilation into a folio. These include the report of the general secretary, the editor and the chairman of the Editorial Board of *The Canadian Nurse,* the provincial reports submitted by the executive secretaries and the National Committee reports. The February 1957 folio contains 76 pages! These reports are discussed, their recommendations considered, a vote is taken and upon general agreement the recommendations are then put into effect. National Office has the responsibility of converting these, your ideas, into action for the spokesmen who have presented them as your representatives.

The following are brief references to some of these reports:

Pension Plan for CNA Members: A proposed pension plan for nurses was drawn up for consideration by the Executive Committee. A representative of the firm which prepared the plan was present at the meeting to discuss it.

Correspondence Course in Nursing Service Administration: Many of you will recall a questionnaire sent out by National Office to directors of nursing asking if any nurses on their staff would be interested in taking a correspondence course for administrators of nursing service who are unable, for some reason, to take the university course in nursing service administration. Those interested also completed a questionnaire. There were 848 questionnaires distributed, of which 215 were returned. Of these at least 125 nurses were interested. The Executive Committee considered whether to go ahead with this project and which method would be most suitable — correspondence courses or institutes.

Pilot Project for the Evaluation of Schools of Nursing: To date some 400 Speakers' Kits have been distributed. Requests for additional study material included in our Loan Folders on Accreditation are now being received. Requests for financial support for the project have gone forward to some seven foundations. The Special Committee on the Pilot Project met on February 18.

CNA Publications: A revision of "What You Want To Know About Nursing" has been completed. Information Services, Department of National Health and Welfare will do the reprinting. With the number of publications handled by this department, it is impossible to estimate when the booklets will be available.

"The Canadian Nurses' Association is Your Association," is presently under revision.

"Job Analysis and Job Evaluation," has been revised and is in the hands of the printer. At the same stage of printing are the revised "By-Laws of the CNA"

Saskatchewan Reports

A Survey in Basic Nursing Education in Saskatchewan was commenced last July. Divided into two parts it includes:

1. An evaluation of the Centralized Teaching Program.
2. A survey of the present status, trends and development of the three-year diploma programs in eleven schools of nursing. The director of the Study is Louise Schmitt, R.N., Ed. D., formerly Director of Graduate Studies in Nursing Service Administration at the University of Iowa.

Each school of nursing and each Centralized Teaching Program Centre through the use of a specially prepared questionnaire wrote their own story. Student nurses also participated through the use of a questionnaire. The report is now being drafted. Congratulations to Saskatchewan on this enlightened aproach to future planning! Other provinces will look forward to the publication of the report which adds to the accumulation of our knowledge of nursing education — its strengths and its weaknesses.

Revision of CNA Policies Regarding Nursing Education

Prior to printing the Nursing Service and Nursing Education Policies in a joint pamphlet, the Committee on Nursing Education submitted a revision of the statement of CNA policies to the Executive Committee for approval. When these are in printed form we shall advise you through these pages and through the CNA Publications list.

Committee on Nursing Service Meets

What are the functions of nursing? What are the staffing requirements for all nursing services? What are some practical methods of research which can be used by nurses? What are the criteria for nursing care? How can we estimate the quality and quantity of nursing service necessary for patients of various ages and disease conditions in hospital, home and industry?

These are some of the problems which the Committee on Nursing Service, meeting in Halifax January 1957, considered in urgent need of study and research.

A large part of the discussions centered around the need for research in nursing. The importance of the small research projects going on in many institutions was stressed.

The committee agreed to make a start by studying the functions, standards and qualifications of the director of nursing service and the head nurse. It is hoped that a manual for head nurses may be developed during this biennium.

With a national health insurance plan being imminent, the committee was concerned about the necessity for developing sound methods for establishing staffing requirements for all nursing services and thought that this should be studied on a national basis.

Guest Speaker

On February 13 Miss Sheila Nixon, Director of Nursing, Children's Hospital, Winnipeg, represented the CNA when she spoke at the President's Conference of the National Council of Women. Her topic was Accreditation of Canadian Schools of Nursing. Information on this topic will eventually spread from the national and provincial to local councils.

Press Clippings

From July to December 1956, 1,249 press clippings on nursing have been received in National Office through the Canadian Press Clipping Service. Of these, 406 dealt with our 28th Biennial Meeting. In all 215 referred to nursing education, 917 to nursing service with a total of 53 French press clippings.

Mental Health Week

Remember these dates April 28 — May 4. That is Mental Health Week. As health workers we all have a responsibility to interpret to the public the problems of the mentally ill and to press for improvements and preventive measures. Let us all be familiar with the mental health services in our community.

6 new books and editions . . . for the nurse!

Brooks — Basic Facts of Pharmacology

Here is a book based on the action of drugs rather than the drug itself. At a glance students can see the similarities and differences of basic drugs. Added learning aids include: a glossary, laws regulating drugs, tables of drug action, summaries, etc.

By Stewart M. Brooks, Ph.G., Science Instructor, Muhlenberg Hospital School of Nursing, Plainfield, N.J. About 384 pages, illustrated. *New.*

Sackheim — Practical Physics For Nurses

Designed for the nurse's exclusive use, this is a non-mathematical text based on nursing experience. It clearly and simply describes the physical laws which underlie the precepts of good nursing practice. Clear illustrations give added visual understanding.

By George I. Sackheim, S.M., A.M., Instructor in Physical Sciences, University of Illinois, Chicago Undergraduate Division; Science Instructor, St. Luke's Hospital School of Nursing, Chicago. 206 pages. $4.00. *New.*

St. Marys Operating Room Technic

This book is a practical guide to up-to-date surgical procedures, supplemented with graphic illustrations. It gives the nurse an understanding of the work of the surgeon — hundreds of operations are clearly defined; the Appendix pictures 210 separate surgical instruments and 13 surgical sheets.

St. Marys Hospital, Rochester, Minnesota. 359 pages, 218 figures. $7.50. *New (5th) Edition.*

Cook and Davidson — Mathematical Guide to Dosages and Solutions

Here is a unique and original approach in presenting fundamental mathematics as applied to nursing situations. Illustrations help clarify many of the difficult principles of *measures, weights, fractions, decimals, per cents, ratios* and *proportions.*

By Alice C. Cook, B.S., R.N., and Katherine E. Davidson, B.S., R.N., Instructors, Delaware, Hospital School of Nursing, Wilmington. 190 pages, illustrated. $2.75. *New.*

King and Showers — Laboratory Guide to Anatomy and Physiology

A laboratory guide to the study of anatomy and physiology rather than a workbook. The contents cover anatomy, physiology, histology and embryology with more emphasis on physiology than any other similar manual.

By Barry G. King, Ph.D., Lecturer in Physiology, University of Maryland, Baltimore; and Mary Jane Showers, Director of Education Program, Christ Hospital, Cincinnati. About 160 pages, illustrated. *New.*

Dennis — Psychology of Human Behavior For Nurses

A fascinating study of people, their actions and emotions, written especially for the nurse. Personality, emotions, defense mechanisms, the theory of needs, psychotherapy and psychosomatic medicine are all covered with illustrative examples.

By Lorraine Bradt Dennis, B.S., R.N., M.S., Instructor of Psychology for Nurses, Pennsylvania State University. 250 pages, illustrated. $3.50. *New.*

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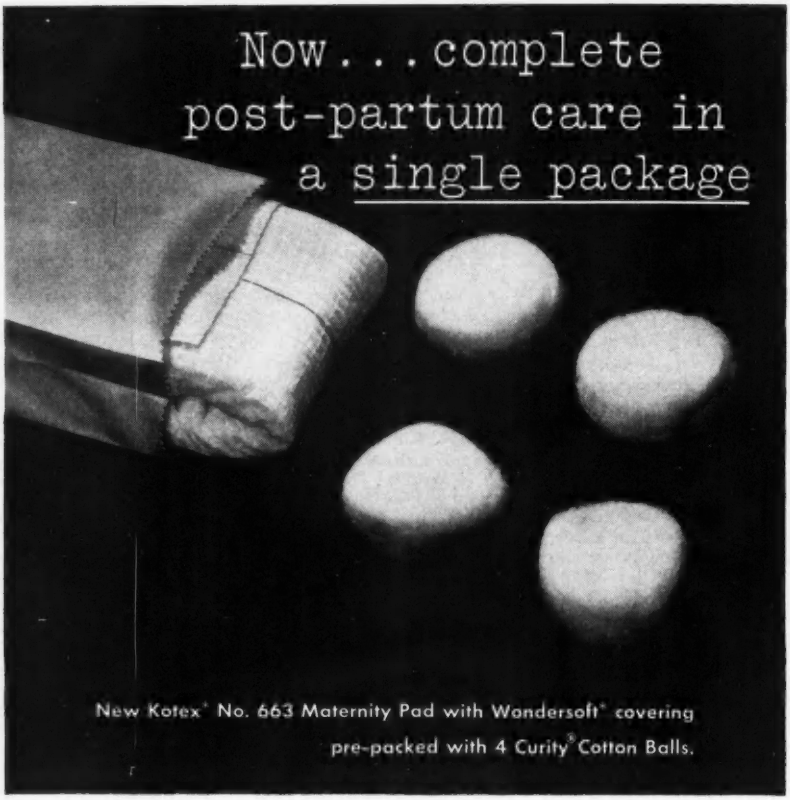

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But, until now, hospitals themselves have had to add the cotton perineal wipes.

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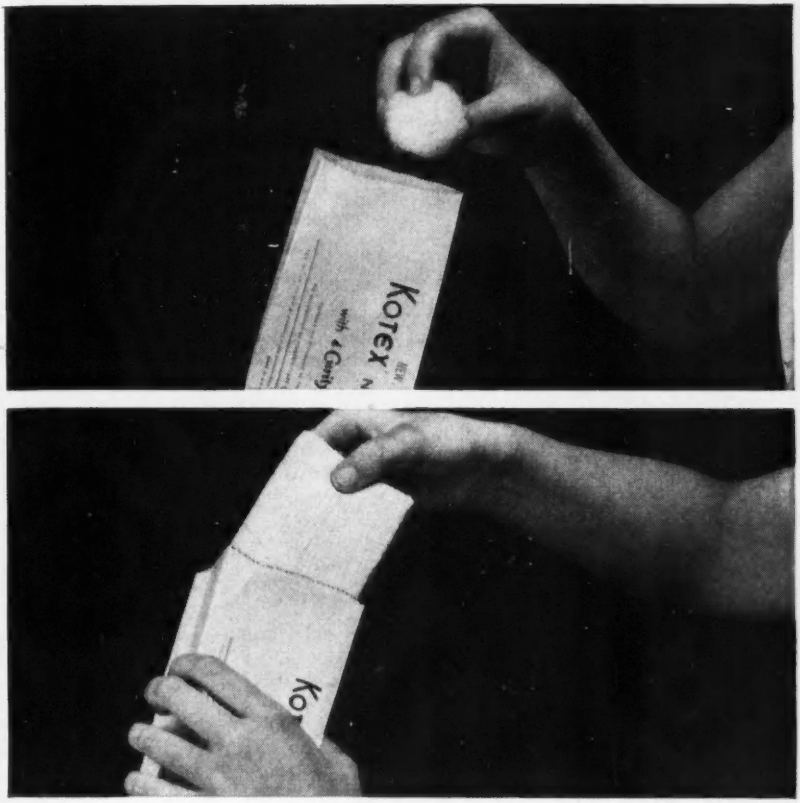

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Le Nursing à travers le pays

Nos Représentantes Nationales

Ottawa et le secrétariat national sont, chaque année, les hôtes de nos représentantes auprès de l'Association nationale lorsqu'en février le Comité Exécutif se réunit au Château Laurier, durant trois jours.

Chaque province sera représentée par la présidente et la secrétaire de son association provinciale d'infirmières. Quatre religieuses représentant les régions de l'Ouest, de l'Ontario, de Québec et des Maritimes seront présentes. Les convocatrices des comités nationaux venant d'Halifax, Frédéricton, Montréal et Toronto et la convocatrice du Bureau de Rédaction de *l'Infirmière canadienne* et la rédactrice de la revue sont toutes membres de l'Exécutif. Mademoiselle T. Hunter de Vancouver, présidente de l'A.I.C. présidera toutes les séances.

Rapports réunis en brochures

Avant chaque assemblée du Comité Exécutif, les rapports sont envoyés au Secrétariat national pour être réunis en brochure: rapport de la Secrétaire-Générale, de la Rédactrice de la revue *l'Infirmière canadienne,* les rapports soumis par les secrétaires provinciales et ceux des comités nationaux, en tout, 76 pages. Ces rapports sont étudiés, discutés, les recommandations en sont examinées, le vote est pris et si la majorité se prononce en faveur des recommandations, elles sont adoptées.

Voici quelques brefs extraits de ces rapports: Un projet de pension de retraite pour les membres de l'Association des Infirmières Canadiennes a été préparé et sera soumis au Comité Exécutif. Un représentant de la Compagnie qui a rédigé le plan assistera à l'assemblée pour discuter de cette question.

Cours par correspondance sur l'administration du service du nursing: Un certain nombre d'entre vous se rappelleront le questionnaire envoyé aux directrices du service du nursing par le Secrétariat National. On leur demandait si, parmi leur personnel, il y aurait des infirmières intéressées à suivre, par correspondance, un cours d'administration du service du nursing, advenant que pour une raison quelconque, elles se trouvaient dans l'impossibilité de suivre ce cours dans une université.

Sur 848 questionnaires distribués, 215 furent retournés, démontrant qu'environ 125 infirmières seraient intéressées à suivre ce cours. Le Comité Exécutif décidera s'il est à propos de mettre ce projet à exécution ainsi que des méthodes les plus appropriées: cours par correspondance, journées d'études, etc.

Le projet d'évaluation des écoles d'infirmières: Jusqu'à présent, 400 pochettes destinées aux conférencières furent distribuées. Nous avons commencé à recevoir des demandes d'emprunt de matériel sur l'Accréditation. Des demandes de financement du projet ont déjà été adressées à sept fondations différentes. Le Comité spécial du projet se réunit le 18 février.

Publications de l'A.I.C.: Une revision de la brochure "Clarté sur la Profession d'Infirmière" vient d'être terminée; le Service d'Information du Ministère de la Santé Nationale et du Bien-Etre en fera l'impression. Considérant le nombre de brochures publiées par ce ministère, il est impossible de dire quand la nôtre sera prête. "L'Association des Infirmières Canadiennes est votre association" est actuellement en voie de revision.

"L'analyse des Tâches et leur Evaluation" a été revisée et est actuellement chez l'imprimeur. Il en est de même des règlements de l'A.I.C.

Rapports de la Saskatchewan. Une enquête sur le cours d'infirmière (cours de base) en Saskatchewan a été commencée en juillet dernier et porte sur deux points:

1. Une évaluation du programme centralisé. (Les cours de probation sont donnés à toutes les étudiantes à deux endroits de la province.)

2. Une étude qui permettra de connaître où en sont les onze écoles d'infirmières qui offrent un programme de trois ans, leurs tendances et leur développement. L'enquête est dirigée par Louise Schmitt, R.N., Ed. D., autrefois directrice de l'enseignement supérieur aux infirmières à l'Université d'Iowa.

Chaque école d'infirmières et chaque centre d'enseignement ont préparé leur rapport à l'aide d'un questionnaire préparé à cette fin. Les étudiantes participent aussi à l'étude et répondent à un questionnaire. On est actuellement à rédiger le rapport de l'enquête. Nos félicitations à la Saskatchewan pour cette étude qui nous éclairera sur la marche à suivre dans l'avenir. Les autres provinces s'intéressent déjà à la publication de ce rapport qui augmentera nos connaissances sur l'éducation des infirmières en en souli-

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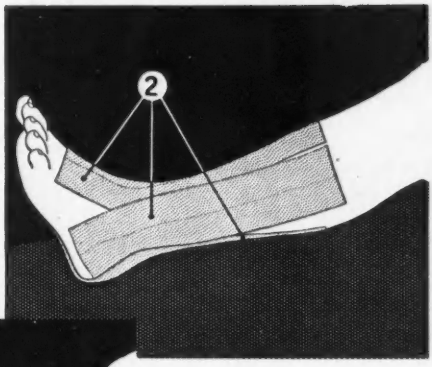
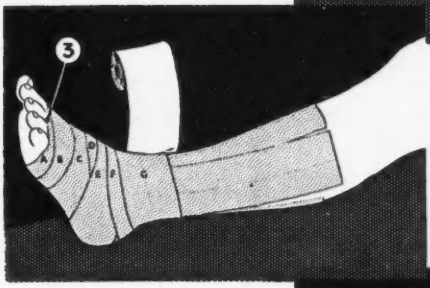
VARICOSE CONDITIONS

1 The leg should be elevated and the foot kept at a right angle to the leg.

2 If the limb is œdematous, or thin or the skin *devitalized*, vertical strips of Elastoplast should be applied before bandaging.





***3** Commencing at the webs of the toes, take two or three turns around the foot, dependent upon its length, and bandage around ankle enclosing heel as illustrated.

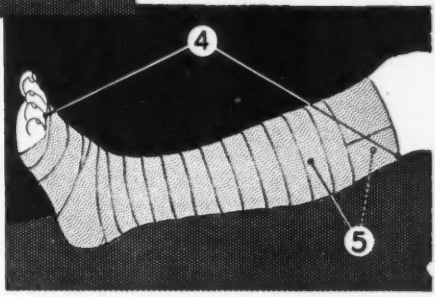
4 Leg should be *covered* from webs of toes to a point just below the bend of the knee.

5 Turns should overlap by at least half the width of the bandage (the yellow line down the centre of an Elastoplast bandage is a guide).

6 No creases.

7 Firm and even pressure proportionate to the amount of induration and œdema present.

** Note bandaging may be made from toes upwards or knee downwards as desired.*



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gnant les points forts ainsi que les faibles.

Revision de la ligne de conduite de l'A.I.C. concernant l'Education des Infirmières: Avant de publier dans une même brochure la ligne de conduite concernant le Service du Nursing et l'Education des Infirmières, le texte revisé de ces ouvrages a été soumis à l'approbation du Comité Exécutif. Lorsque cette brochure sera imprimée, nous vous en informerons dans ces colonnes et l'indiquerons sur la liste des publications de l'A.I.C.

Conférencière invitée

Le 13 février, Mlle Sheila Nixon, directrice du nursing au Children's Hospital de Winnipeg, représentera l'A.I.C. à la réunion des présidentes du National Council of Women à laquelle elle sera la conférencière invitée. Le sujet traité sera l'Accréditation des Ecoles d'infirmières du Canada et les renseignements donnés à ce sujet s'étendront du domaine national et provincial aux conseils régionaux ou de district.

Le Comité du Service de Nursing se réunit

Quelles sont les fonctions des infirmières? Quel est le personnel requis pour le soin des malades? Quelles méthodes pratiques de recherche peuvent être employées par les infirmières? Par quels critères peut-on juger de la valeur des soins? Comment peut-on évaluer la qualité et la quantité de services nécessaires aux malades, se basant sur l'âge et la maladie, à l'hôpital, à domicile et dans l'industrie?

Voilà autant de problèmes que le Comité du Service du Nursing, réuni en assemblée, à Halifax, jugea à propos et urgent d'étudier.

Une grande partie de la discussion porta sur la nécessité de la recherche en nursing. L'importance de la recherche en nursing, même dans les petites choses, qui se poursuit dans bien des institutions, fut soulignée.

Le comité décida de commencer par l'étude des fonctions, des normes et de la préparation de la directrice du service du nursing et de l'hospitalière. L'on espère d'ici deux ans préparer un manuel pour l'hospitalière.

A notre époque, la réalisation d'un projet d'assurance-santé nationale semble imminente; le comité est préoccupé de la nécessité d'établir, par de bonnes méthodes, le personnel requis dans tous les services du nursing et exprima l'avis que cette étude devait être faite à l'échelle nationale.

Coupures de presse

De juillet à décembre 1956, le service "Canadian Press Clipping" a fait parvenir au Secrétariat National 1,249 coupures se rapportant aux infirmières. De ce nombre, 406 ont trait au Congrès biennal, 215 à l'éducation des infirmières, 917 au service du Nursing; 52 étaient en français.

Un coup d'oeil sur l'accréditation

Pour toutes celles qui se proposent de parler sur l'accréditation des écoles d'infirmières à des groupes d'infirmières ou à des réunions de personnes en dehors de la profession, un feuillet en résumant les points principaux a été préparé par le Secrétariat National de l'A.I.C. Vous pouvez vous procurer ces feuillets pour les distribuer à vos auditeurs.

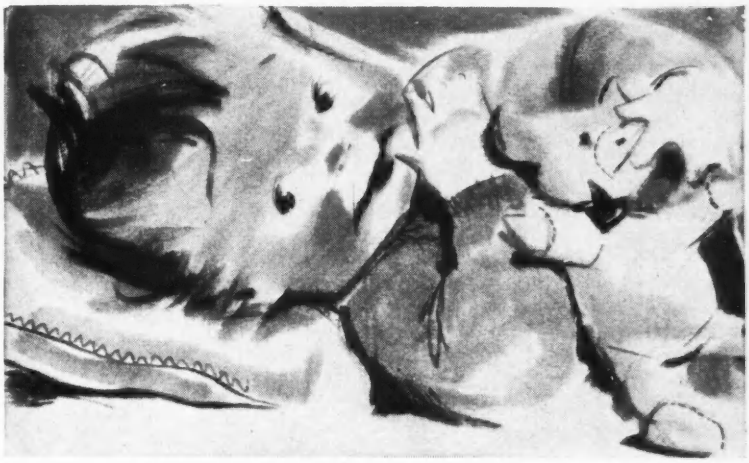
Semaine de la Santé Mentale

N'oubliez pas ces dates: du 28 avril au 4 mai, ce sera la semaine de la Santé Mentale. A titre d'infirmières, nous avons toutes le devoir d'expliquer au public les problèmes des malades mentaux et d'insister sur les améliorations qui peuvent être apportées et sur les moyens de prévention. Renseignons-nous au sujet des services d'Hygiène Mentale de notre ville ou de notre localité!

The Food and Drug Administration has published an order denying proposals to permit sale, without prescription, of ointments and lotions containing hydrocortisone and hydrocortisone acetate. These products are often prescribed for relief of various skin disorders.

According to the Commissioner's statement, the available evidence fails to show that these drugs are safe for use without medical supervision. In particular, there is insufficient evidence to show the range in the amount of hydrocortisone that is absorbed through the skin and the clinical significance of such absorption.

—U.S. Dept. of Health, Education and Welfare



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In Memoriam

Helen (Glenny) Addison, who graduated from Toronto General Hospital in 1929, died suddenly in Toronto on November 21, 1956.

* * *

Dorothy Bjornson, who graduated from Winnipeg General Hospital in 1954, was a stewardess on the Trans-Canada Airlines flight that disappeared on December 9, 1956. Prior to joining the T.C.A., Miss Bjornson engaged in public health nursing at Swan River, Man.

* * *

Christina Mae (Cardwell) Byam, who graduated from Toronto General Hospital in 1927, died suddenly at her home in Millbrook, Ont.

* * *

Jessie (Plaxton) Clark, who graduated from Toronto General Hospital in 1916, died at St. Catharines, Ont. on December 5, 1956.

* * *

Gertrude L. Craig, died at Meadow Lake, Sask., on December 19, 1956. Miss Craig had worked in hospitals at Regina, Qu'Appelle and Indian Head.

* * *

Lenora (Stevenson) Dickson, who graduated from Toronto General Hospital in 1921, died at Amsterdam, N.Y.

* * *

Margaret Isabella Galloway, a Scottish nurse who worked in Hamilton, Ont., many years ago, died at Nanaimo, B.C., on January 7, 1957 after a short illness.

* * *

Anna Grisdale, who graduated from Toronto General Hospital in 1915 died suddenly. She had engaged in private nursing for many years.

* * *

Olive (Woodruff) Hardwick, who graduated from Greater Niagara Hospital, Niagara Falls, Ont., in 1937, died there on February 9, 1957 following a lengthy illness. Mrs. Hardwick was an active member of the Industrial Nurses' Association. She was employed for many years with the North American Cyanamid Company in Niagara Falls.

* * *

Mrs. W. T. Hays, who graduated in Northampton, Mass., early in the century and who served overseas with the C.M.A.C. during World War I, died at Edmonton on February 13, 1957 at the age of 73.

* * *

Elizabeth (McKague) Kilbourn, who graduated from Toronto General Hospital in 1924 died at Owen Sound, Ont., on November 25, 1956.

* * *

Pearl (Allen) McCullough, who graduated from Toronto General Hospital in 1910, died at Long Beach, California.

* * *

Joyce Milne, who graduated from Vancouver General Hospital in 1944, died suddenly at Vancouver in December, 1956 at the age of 36. After two years in the R.C.A.F. nursing service, Miss Milne became assistant superintendent of the Children's War Memorial Hospital in Vancouver. She was taking a course in public health nursing at the University of B.C. at the time of her death.

* * *

Hilda Purdy, who graduated from Victoria General Hospital, Halifax, in 1925 died at Edmonton on January 28, 1957 following a brief illness. Miss Purdy spent most of her professional life at the Halifax Tuberculosis Hospital, being matron there when she became ill.

* * *

Zeta (Sweeney) Rowan, who graduated in Manchester, N.H. and engaged in private nursing in Saint John, N.B., died there on September 25, 1956.

* * *

Winnie Smith, a graduate of Toronto Orthopedic Hospital, died at Guelph, Ont. on December 24, 1956 after a long illness. After engaging in private nursing for several years, Miss Smith operated a nursing home until illness forced her to give it up.

* * *

Elsie (Plumpton) Tilley, who graduated from Toronto General Hospital in 1945, died there on December 14, 1956.

* * *

Jeanette V. White, editor of the *American Journal of Nursing* (see *The Canadian Nurse*, January 1957) died suddenly at her home in New York on March 4, 1957.

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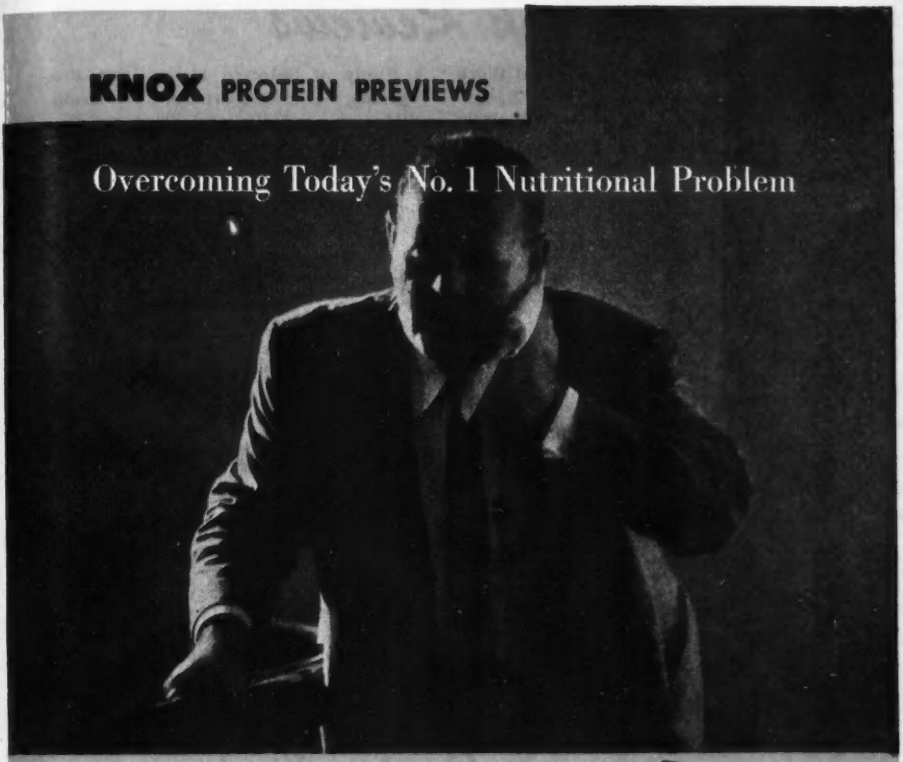

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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Book Reviews

The Operating Room Supervisor at Work by Edna A. Prickett, B.S., R.N. 112 pages. Department of Hospital Nursing, National League for Nursing, 2 Park Ave., New York 16, N.Y.

Reviewed by Miss Merle Smith, Operating Room Supervisor, Ross Pavillion, Royal Victoria Hospital, Montreal.

The modern concept of total patient care requires that the operating room supervisor be a member of the hospital's administrative team, along with the executive director and the director of nursing service. General social and economic changes in employment practices and labor shortages test the operating room supervisor's technical skills and her ability to lead her fellow workers in getting the work done. The increased use of nonprofessional staff and the reduction in the work week for all personnel directly affect her.

The purpose in writing this book was to assist those who are and those who wish to be operating room supervisors. The text contains an outline of:

1. The general principles of the organizational structure within the hospital and the operating room.

2. The standards, including minimum requirements, for use of the person or persons responsible for selecting nursing service personnel; for providing adequate service to surgeons; for promoting satisfaction among workers not only within the operating room but in the other departments related to it.

3. The number of committees and functions delegated to them for hospital control or administration.

4. The supervisory activities — a. type of work performed; b. assignment of personnel; c. maintenance of physical and technical efficiency; d. an educational program for the orientation of the new employees and a continuous program for all the members of the staff.

This book also provides a guide in architectural planning and reference material for clinical programs. It helps to give administrators and surgeons an appreciation of the operating room supervisor's functions and responsibilities.

The material is easily understood. It may refer on the whole to larger institutions but the basic concepts may be applied to smaller units. This book could be used as a guide for operating room supervisors.

A Study of Selected Home Care Programs. U.S. Department of Health, Education and Welfare. 128 pages.

Reviewed by Miss Hazel Miller, Director of Nursing, Reddy Memorial Hospital, Montreal.

This publication, with a foreword by Leonard A. Scheele, formerly Surgeon General, United States Public Health Service, is in two parts.

Part I — is a general review of the entire study which was undertaken for the following purposes:

1. To obtain basic factual data describing the objectives, organization, development and operation of Home Care Programs.
2. To identify basic factors to be considered in the establishment and operation of Home Care Programs.
3. To describe the use of Home Care Programs for professional education.
4. To make this information available to program operators, consultants and persons interested in planning new programs.

Part II — describes in considerable detail the programs of the eleven plans surveyed. These differ markedly as to types of patients served, administration, services rendered and methods of financing.

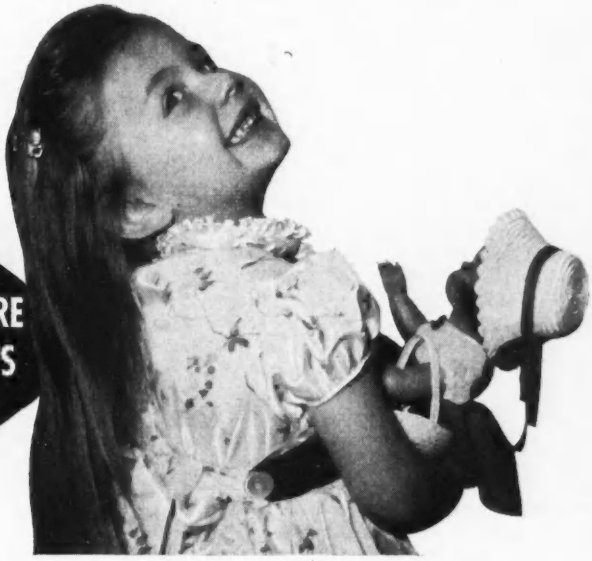
To the uninformed reader these differences may easily prove confusing, although the Study Committee should be credited with success in reaching its goals. A pattern of benefits or advantages emerges in all programs:

1. Provision of complete and integrated care to patients at minimal cost.
2. The important contribution made by Home Care plans to the education of medical, nursing and social work students.

Only two programs mention what should be considered one of the most important "raisons d'être" of such plans, that is the alleviation of the shortage of hospital beds without construction costs. Furthermore, there are two prerequisites for any Home Care plan, which may be obvious to the reader but which ought to have had special mention; a. A community visiting nurse association, b. A resident interne staff (or equivalent substitute) at the local hospital.

From the point of view of organizers of new schemes, this brochure should not be considered a blue print.

IF THERE'S MORE THAN MEETS THE EYE



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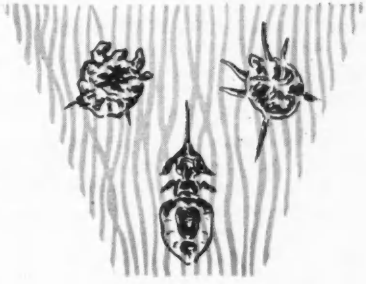

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Montreal 30, Que.

The Administration of Health Insurance in Canada by Malcolm G. Taylor. 270 pages. Oxford University Press, Toronto, 1956. Price $5.00.

At no other time, perhaps, have Canadians been so health-conscious or health insurance-minded. Health programs in industry, in schools, in the commuunity and publicity through the press help to account for the former. Bitter experience in trying to meet the costly effects of medical care and hospitalization *without* some type of health insurance plan helps to account largely for the growing interest in the latter.

This book is recommended reading for lay and professional persons desiring an overall picture of the present status of health insurance in Canada. Many and varied "health plans" or "health insurance" schemes are presently in existence. A representative group of the better known schemes are concisely described. The objectives of the insuring agencies and the possible effects that differences in these objectives may have on the organization and function of administrative bodies and on the pattern of medical and hospital care are considered.

Provincial enabling legislation is as diverse in nature as the variety of agencies. The legal status of prepaid plans must be, and is, determined mainly by whether or not the services offered constitute insurance. The legislation and supervisory powers of specific provinces are discussed in some detail.

With so many plans from which to choose, the prospective participant wants to know the relative merits in terms of the benefits offered and is sometimes perplexed by the differences existent between one plan and another. The determination of benefits is explained and clarified. The method by which premiums are decided is described as well as the means through which payment is made to those who provide medical services.

Controls are necessary to prevent the tendency towards over-use or even abuse on the part of some subcribers, hospitals, and members of the medical profession. The exercise of controls is outlined in considerable detail.

The book concludes with a discussion of some of the problem areas still to be studied and solved.

* * *

Lippincott's Quick Reference Book for Nurses by Helen Young, R.N. and Eleanor Lie, A.B., R.N. 727 pages. J. B. Lippincott Co., 4685 Western Ave. Montreal 25. 7th Ed. 1955. Price $4.00.

Reviewed by Miss Alice Gage, Educational Director, Victorian Order of Nurses, Bishop Street, Montreal.

This edition is, as the authors state, "an inclusive yet quick source of knowledge." It supplies the nurse with a comprehensive review of information relating to nursing care. The book has been enlarged to bring the newer thinking in the fields of medicine, surgery, obstetrics, pediatrics, nutrition and pharmacology.

The material has been arranged in five sections. 1. Pharmacology 2. Medical and Surgical Nursing 3. Nursing Techniques 4. Diet Therapy 5. Maternity Nursing including child care. These areas have been revised and reorganized to correspond to the changes in nursing practice. An appendix is included covering tables of measurements; poisons, symptoms and treatments; diagrams of pressure points in relation to bleeding.

The edge index is an innovation that should prove helpful in locating material.

This reference book should be of value to any nurse who needs medical and nursing information quickly.

* * *

District Nursing by E. J. Merry, S.R.N., S.C.M., M.S.C.P., Q.M. & H.V. Certs, and I. D. Irven, S.R.N., S.C.M., Q.M. & H.V. Certs. 258 pages. The Macmillan Company of Canada, 70 Bond Street, Toronto, Ont. 2nd Ed. 1955. Price $3.00.

Reviewed by Miss Dorothea Atkinson, District Supervisor, Victorian Order of Nurses, Bishop Street, Montreal.

The authors give a clear presentation of the structure and organization of district nursing and of the functions of the district nurse in England. The historical development is briefly traced.

Specific nursing techniques and the principles which underlie the establishment of them are discussed in detail. Many of the fundamental principles and techniques may be applied by the public health nurse, regardless of where she works, in her relationship to the patient, to his family, to members of the health team and others in the community. Special chapters, units in themselves, deal with specific subjects such as nutrition and food values, tuberculosis, and family health teaching.

This book can be used as quick reference for those who are already engaged in public health nursing. It also serves to give a picture of public health nursing to those who are planning to enter the field.

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Congestive Heart Failure with Uremia

CARL T. V. WILSON

ANATOMY AND PHYSIOLOGY

THE URINARY SYSTEM is composed of two kidneys, two ureters, the cystic bladder and the urethra. The kidneys consist of three divisions: *Cortex,* the outer, secretory part containing the blood vessels, glomerati and smaller tubes. Urine is filtered here. The *calyces* which are larger collecting tubules that lead into the *pelvis,* a reservoir which conveys the urine to the ureters. The function of the kidneys is the secretion of urine, the excretion of waste materials and the maintenance of both water and salt balance of the blood.

The heart, lying in the centre of the thoracic cage between the lungs, has three coats — the *pericardium* which is fibrous; the muscular layer, the *myocardium;* the inner lining, the *endocardium.* Divided into four chambers, the upper pair, the atria receive blood; the lower pair, the ventricles, discharge it. When the myocardium is unable to fulfill its function in propelling blood throughout the system, stagnation occurs and "heart failure" is said to have taken place. The resulting congestion causes an increase in blood pressure. Poor oxygenation of the blood occurs and a characteristic blueness of the face and neck may be observed.

CHEMISTRY CORRELATION

By the process of osmosis and secretion the kidneys excrete toxic products of combustion from the body in the form of urine. Urine is composed of water, both organic and inorganic end-products and nitrogenous wastes. Inorganic salts include sulphates, phosphates, calcium, etc. On the other hand, urea and creatinine are among the organic constituents. Urea is more abundant, forming about 50 per cent of the solid materials. Normally urea is excreted at the rate of 20 to 40 grams a day. Abnormally, less is excreted and more is accumulated in the blood. Such a condition is common in uremia.

Uremia is the term used to describe a group of clinical symptoms. It is not a disease in itself. It is often associated with nephritis or other conditions in which there is damage to the kidneys. The signs and symptoms include headache, foul breath, nausea and vomiting, convulsions and coma. Urine output varies from normal or increased in chronic renal failure to almost complete suppression in the acute form. In this instance, the onset was sudden and rather unexpected since the past history did not reveal previous kidney disorder.

Congestive heart failure is a condition of the cardiovascular system. It is characterized by dyspnea, cyanosis, edema, a rapid, weak, irregular pulse. Sometimes there is a change in the normal waves of the EKG. Fluids are generally restricted with a light, nourishing diet. A fluid balance chart is a "must" in all cases. Morphine, diuretics and digitalis preparations are of special value in treatment.

The following case history illustrates the correlation between heart and kidney involvement.

CASE STUDY

Mr. West, aged 45, a sergeant major in the regular army, was admitted to the medical ward one evening. He complained of shortness of breath and general malaise. Incidence of congestive heart failure among members of the armed forces is comparatively rare due to the careful diagnostic tests given to recruits prior to enlistment. Many years had passed since Mr. West had received his pre-enlistment examination during which he had engaged in strenuous activities, including war service.

It was decided to place Mr. West in the small ward nearest to the head nurse's

---

Mr. Wilson did this nursing care study as an intermediate student at the St. John of God Brothers Hospital, Yorkshire, England. He had had six months training at St. Paul's Hospital, Saskatoon, before transferring to that monastic school.

Most doctors feel it is wisest to continue the infant's evaporated milk formula for six months, adjusting it from time to time to meet his changing needs. Evaporated milk processing makes it easier to digest than fresh milk. This is an important point, since digestive upsets and diarrheas are more difficult to treat and potentially more serious during infancy.

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office. Through a large glass panel all of the acutely ill patients in that room can be watched more easily. He was put immediately into a warm bed, in Fowler's position. A pillow was place on the bedside table, which was moved across the bed in front of him, so Mr. West could lean forward comfortably to assist his breathing. The locker was moved into a suitable position so he could reach it easily.

With a temperature of 99°, Mr. West's pulse was bounding and full, at 110 beats per minute. His respirations — 35 — were very labored. To relieve the dyspnea oxygen, litres 6 per mask, was started. A very tall man, weighing some 180 pounds, Mr. West's legs were very edematous so a bed cradle was used to relieve his limbs of the weight of the blankets.

A tentative diagnosis of congestive heart failure was made following the doctor's examination that evening. No indication was elicited of previous cardiac or nephritic disease. Sodium amytal, gr. 3, intermittent oxygen therapy and a salt-free diet with restricted fluids were ordered.

Mr. West had served in the army for 15 years, for the past six as a recruit instructor. His wife had died five years previously with cancer of the stomach. He seldom saw his only daughter, aged 14, who lived with relatives in a distant part of the country.

He appeared very lonely and insecure in this new environment. In addition to worries over his diagnosis and prognosis, there were social problems of no little importance. Mr. West was very concerned about the welfare of his child. Recognizing all of the psychosomatic factors, we attempted to reassure him. He was very talkative and most of his conversation was about his problems. He became very annoyed if one did not remain to listen, though he spoke slowly and was very repetitious. We tried to divert the conversations to other topics without too much success. Radio ear phones and magazines were provided in an attempt to persuade him to avoid overtaxing his strength by so much talking. He was asked to refrain from smoking and an explanation was given of the reasons for this restriction.

Treatment

Second day: The medical consultant who examined him ordered that he be put on the Rice diet. A diuretic, mersalyl 2 cc., was administered in combination with aminophyllin 200 mgm. After giving this medication the edema was carefully observed. Fluid intake was restricted to 400 cc. whereas output was 860 cc.

It was difficult for Mr. West to go to sleep unless there was a nurse within his range of vision. He feared the darkened room so a portable lamp was placed by his bed. Then he slept well.

Third day: Though the fluid balance was satisfactory, Mr. West vomited copiously. An extra pint of fluid was permitted during the day to compensate for the loss through emesis. Oral hygiene was given to remove the unpleasant taste. Care was taken to ensure adequate ventilation and a pleasant odor in the patient's immediate environment.

Fourth day: Mr. West felt somewhat better. His blood pressure was lower and the dose of liquid paraffin given the evening before produced a good bowel movement. Deep breathing exercises were encouraged.

Fifth day: The clinical symptoms of uremia were recognized and the Rice diet was stopped. Nutrition presented quite a problem. With uremia Mr. West needed a nourishing diet with good fluid intake. On the other hand, fluids had to be semi-restricted to avoid overtaxing the heart that was already in distress. Salt was added to the diet and the urinary chlorides were to be estimated each morning. Normal is 3-6 grams. The first morning Mr. West's urine showed only one gram.

Sixth day: Mr. West had a poor day taking only sips of water. Special care was given to his mouth and his dry, chapped lips were lubricated frequently. Due to the marked edema attention to pressure areas was given every four hours. His rest was very disturbed by bad dreams from which he would awake cold and trembling. An extra blanket, a hot water bottle at 110°, and finally a glass of warm milk enabled him to sleep the remainder of the night.

Seventh day: Normal saline was ordered but Mr. West did not like the restraint necessary on his arm for an intravenous. As an alternative, a rectal drip was started. The drip was maintained at 40-50 drops per minute in order not to stimulate the defecation reflex. Mr. West was kept warm and as comfortable as

no need to be

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possible throughout the long procedure.

Eighth and ninth days: These were uneventful days. Urinary chlorides reached 5 grams. Blood urea that is normally 20-40 mgm. was found to be 436-480 mgm.

Tenth day: Mr. West appeared very restless. His fluid balance chart revealed that he had not voided for many hours. Moist warm compresses were applied to the pelvic area for half an hour with success. He voided 540 cc. Since he complained of flatulence permission was secured to introduce a flatus tube which relieved the patient considerably. Later, an enema was given with good results.

Eleventh day: During the morning Mr. West rested fairly comfortably. By noon he began to hiccough. Deep breathing exercises were encouraged to relieve the spasm of the diaphragm. There was no evidence of retention. The patient described sudden excruciating pain in the upper left costal region. The resident physician ordered morphia gr. ¼ and called for a special nurse. The morphia relieved much of the pain and stopped the hiccoughs. Oxygen therapy was made continuous.

Later, the medical consultant visited Mr. West. The doctor ordered a blood transfusion of packed cells. Half-hourly pulse and blood pressure counts were taken. The patient's face was sponged frequently to relieve the profuse perspiration. Mr. West voided satisfactorily during this period.

His condition deteriorated rapidly in the afternoon. Respirations became stertorous. Frequent oral care was necessary to remove the large quantity of mucus that collected in his mouth. Mr. West's skin was cold although he did not complain of any feeling of being chilled. Despite medical and nursing efforts, the patient died late in the afternoon.

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6. The author's appreciation is expressed to Sister Minehan for her assistance in the preparation of the study.

Sélection

(Suite de la page 288)

dose de moitié.

En outre, il faut ajouter quotidiennement deux litres d'eau bicarbonatée, ingérée de préférence par la bouche pour faciliter l'excrétion rénale.

Dès son arrivée, on pèse le brûlé et l'on demande une numération globulaire et un calcul de l'hématocrite.

Ce dosage réitéré de l'hématocrite permet de suivre de très près la réhydratation et d'éviter les "surtraitements."

On les remplace maintenant par un procédé plus rapide: La mesure de la diurèse horaire dont le taux normal doit osciller entre cinquante et cent centimètres cubes. Au-dessous de 50 cc. on fait une épreuve de charge (un litre de plasma en trois quarts d'heure) et en cas de persistance de l'oligurie, il faut:

Soit remplacer le plasma par des injections de sérum sulfaté sodique ou de sérum glucosé hypertonique;

Soit en cas d'échec, pratiquer une infiltration lombaire, une décapsulation et surtout une dialyse péritonéale.

Les boissons seront données à volonté. Le sérum antitétanique est de rigueur et sera renouvelé le 15ième jour.

Après 48 heures: La polyurie doit se produire entre la 48 et la 60ième heure. Dans tous les cas il est dangereux de continuer les perfusions intraveineuses car, à ce moment, l'oligurie si elle se manifeste est d'origine rénale. On assiste en effet, après la 48ième heure, à un renversement du sens de la perméabilité capillaire. A cette période:

En cas d'anurie, il faut encore recourir à la dialyse péritonéale;

Mais, en cas de persistance de la polyurie, on doit s'opposer à la dilution sanguine par une alimentation riche en protéines et

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en hydrates de carbone (4000 calories quotidiennes), par la polyvitaminothérapie et par des transfusions de sang ou d'une solution concentrée de globules.

La guérison des brûlures superficielles se fait en quinze jours. En face de brûlures profondes, où le risque d'infection est grand, il faut employer les antibiotiques, mais seulement après un test de sensibilité microbienne, et suppléer par des greffes à une cicatrisation déficiente.

TRAITEMENT LOCAL

Tous les pansements doivent être faits aseptiquement et préparés soit à la cicatrisation spontanée, soit les traitements ultérieurs.

Dans un premier pansement, on déterge la brûlure avec du Cétavion, on ponctionne les grandes phlyctenes, puis on applique sur toute la surface brûlée de la gaze vaselinée, plusieurs épaisseurs de gaze sèche, de coton hydrophile, de coton cardé et l'on maintien une compression modérée.

Ce premier pansement est laissé en place à 14 jours, puis il est enlevé avec les mêmes précautions d'aseptie.

Si les brûlures étaient superficielles, la cicatrisation est faite et on enlève les compresses vaselinées.

Si les brûlures étaient profondes, cet examen du quatorzième jour montre ou bien une surface bourgeonnante, rouge et de bon aloi qui permet d'envisager des greffes rapides, ou bien des escharres grisâtres, avec une suppuration sous-jacente.

Dans ce cas, il faut envisager une irrigation continue type Carrel ou une excision des escharres et des greffes ultérieures.

Enfin, dans les formes graves, avec un état général menacé, on peut tenter une homogreffe (prise à la mère ou à un frère par exemple). Elle s'éliminera presque certainement en 15 ou 20 jours, mais elle aura joué un rôle de pansement biologique et amélioré souvent l'état de ces grands brûlés.

— *Bulletin Officiel de L'Association de Médecine du Travail*, mars 1956.

Quick Glance at Accreditation

For all those who plan to address professional or lay groups on accreditation of schools of nursing, a small leaflet summarizing the main points has been prepared by National Office. These may be ordered in quantity for distribution to your various groups, including students.

News Notes

ALBERTA

BANFF

Twenty members attended the first meeting of the current year with Mrs. Gourlay presiding. Members accepted the responsibility of canvassing for the Cancer Society during the annual campaign in May. Preparations are underway for the provincial convention which is to be held during the same month with the local chapter acting as hostess. The nurse recruitment campaign is a project of immediate concern. With the assistance of the Home and School Association, displays are to be placed in local store windows. A refresher course is planned for the near future to be carried out with the assistance of the local doctors.

EDMONTON

General Hospital

Mrs. Randall was the guest speaker at the annual alumnae banquet held early this year. The junior Glee Club under the direction of Mrs. Patricia Currie presented several numbers. Miss B. Hockaday has come from Texas to the position of obstetrical instructor. Twenty-one nurses recently completed their course of study and obtained the coveted black bands for their caps. Thirty-three preclinical students received their caps at a ceremony in February. O. Cornelius received *The Canadian Nurse* award. W. M. Day, educational director, attended the Civil Defence Course at Arnprior. Members of the faculty attended a workshop held at the MacDonald Hotel early in the year.

BRITISH COLUMBIA

CRANBROOK

Mrs. M. Kyle presented her report of the councillors' meeting held last fall in Vancouver at a dinner meeting of the chapter. Members elected the new executive for the current year. The officers include: Mrs. E. Barnhardt, pres.; Mrs. M. Huxtable, sec.; M. Lewis, Treas.

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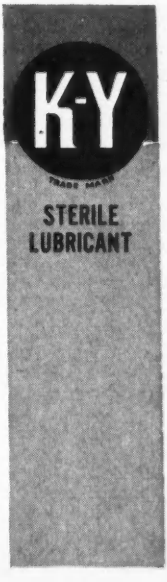

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Members of the Plateau chapter were greatly interested in an address given by Dr. G. I. Theal on "Replacement Transfusion in Blood Diseases of the Newborn." Sr. Margaret Ann outlined the nursing care for such patients. At later meetings, M. Cutler reported on a provincial council meeting and described a visit to the Child Guidance centre. G. Suter showed films of the blood transfusion service of the Red Cross Society. Dr. Scholefield was the guest speaker at a more recent meeting. Elected to office for this year were: M. Cutler, pres.; Mrs. M. Hind, vice pres.; Mrs. P. Robinson, sec.; Mrs. J. Guthrie, treas.

Kamloops

The annual chapter report as presented by M. Rowles, retiring president, showed a very active and successful year for 1956. Programs showed considerable variety and numerous projects were undertaken by the group. A scholarship was given to one person. The graduating class of the hospital was entertained and gifts were given to the members. A Christmas party for the students was sponsored by the association. A prize was given for the best case study submitted. A collection of clothing for the Essondale Apparel Shop was made and curtain material was donated to the Pleasant Street School. The president and treasurer of the chapter were interviewed on a radio broadcast.

Penticton

The first chapter meeting for 1957 was held in the nurses' home early in January The new executive includes: Mrs. C. Rothfield, pres., Mrs. I. Browne, vice-pres.; C. Wade, treas.; Mrs. H. Skermer, sec. Conveners for the Spring dance were appointed. A film "Cataract Extraction" was shown following the business session.

Penticton Hospital

Miss Mary Ellen Walker, director of nurses was the honored guest when members of the local chapter entertained at a farewell party late in January at the nurses' residence. Among the sixty guests present were the nurses and professional members of the hospital staff.

The highlight of the evening was the presentation of a watch to Miss Walker by Mrs. C. Rothfield. Miss Walker, who has been the matron for six and a half years, accepted a position at Woodland, California.

Vancouver

St. Paul's Hospital

At the January meeting of the alumnae association, members enjoyed an address by Dr. M. Ellis of Woodland School, New Westminster. Woodland School, is a provincial institution for the care of the mentally

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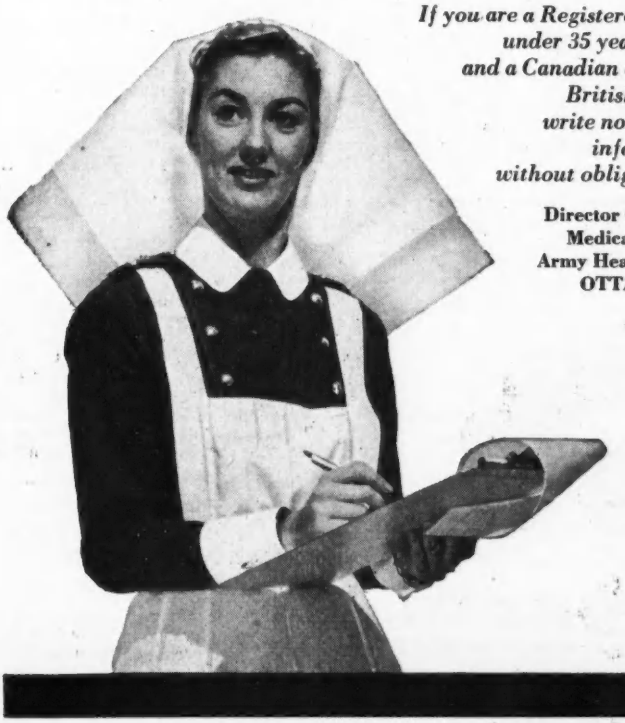

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deficient. Dr. Ellis described the work done by the staff and showed a film taken in the school. Dr. E. Skwarok spoke on "Neurosurgery" at the February meeting.

Plans are progressing for the Jubilee celebration that is to be held June 10, 11 and 12. Class reunions are planned for June 13. Mrs. Dawe is preparing a history of the school of nursing for the occasion. E. Black, 2765 W. 33rd Ave., is the registrar and is also in charge of information. A supper dance is planned for June 14 at the Stanley Park Pavilion. Since the ticket supply is limited, interested members are urged to make their reservations early.

Sr. M. Celina, Sister Superior, recently left the hospital. Sr. Celestine is on the staff of the Creche in Calgary. B. Wilson is working in Trail. D. Brehle is engaged in public health work in the Kamloops district. Miss Langley, matron of Nicola Valley General Hospital, recently resigned to be married. N. Alleyn is now on the staff of the Royal Jubilee Hospital, Victoria. J. Todd, R.C.A.F. nursing sister, was recently transferred from Metz, France, to Greenwood, Nova Scotia. A. Brown is engaged in missionary work in Formosa.

MANITOBA

District 2

Brandon

The January meeting of the district was held at the Brandon Sanatorium. It took the form of a buffet supper meeting, followed immediately by a short business session. The Sanatorium staff, under the direction of Mrs. I. Cruikshanks, superintendent, formed a panel and discussed fully the problem of tuberculosis as it is dealt with at that hospital. This was very ably presented, and proved most interesting to the sixty nurses in attendance.

General Hospital

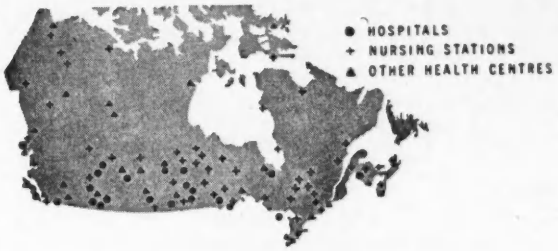
An alumnae association was organized early in February under the chairmanship of M. E. Jackson. Executive members elected were: Mrs. H. S. Perdue, pres.; P. M. Long, vice-pres.; R. Lane, sec.-treas. Arrangements were made to hold a tea. Tentative plans were drawn up for a reunion of graduates as part of the celebrations in conjunction with the hospital's 75th anniversary in June.

Winnipeg

Misericordia General Hospital

Twenty-eight students received their caps from Sister St. Odilon, director of the school of nursing, early in February. Symbolic lamps were presented by Miss M. Lacroix, associate director, while M. Boivin, president of the student organization, performed the candle lighting ceremony. *The Canadian Nurse* award was presented to J.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



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(3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.

(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

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Lowe. The Gideon Society gave gifts of Bibles to non-Catholic students.

A very successful tea and sale of home cooking and sewing was sponsored by the alumnae association early in the year. It was held in the Beaver Hall of the Hudson Bay Company store.

St. Boniface Hospital

The annual dinner and a general meeting of the alumnae association was held early this year in the nurses' dining room. The gold medallist of the class of 1907, Mrs. A. Emes, was presented with an honorary membership. A gift of $400 was presented to Sr. Jarbeau to be used in furnishing a day room on behalf of the association. Installation of the new executive for the current year concluded the business meeting. The slate of officers includes: Sr. D. Clermont, hon. pres.; Mrs. R. H. McNaughton, pres.; T. Greville, D. McDonald, vice-pres.; Mrs. M. Shaw, treas.

Victoria General Hospital

A tour of the new residence followed the business session of a recent alumnae meeting. Plans were discussed for the annual graduation dinner. A new executive was elected to office and includes the following members: J. Angus, pres.; Mrs. E. Backhouse, vice-pres.; Mrs. M. Roper, sec.; Mrs. J. Gowler, treas.

NEW BRUNSWICK

MONCTON

A panel discussion of the Russell Report on nursing education in the province proved very interesting to chapter members at a recent meeting. The panelists were: E. Larracy, K. Richardson, B. Jenkins, Dr. A. M. Clarke and Father Cormier. Student nurses from the Moncton Hospital and Hotel Dieu Hospital were guests for the occasion.

Nurses' Hospital Aid

The first meeting of the year was held in the nurses' residence of Moncton Hospital. Election of officers for the current year was held and the following members form the executive: Mrs. M. Buxton, pres.; K. Richardson, hon.-pres.; Mrs. M. MacAuley, Mrs. D. Van Buskirk, vice-pres.; Mrs. B. Oke, rec. sec.; Mrs. A. Allen, cor. sec.; Mrs. J. H. Pettigrew, treas. Miss A. J. MacMaster was made an honorary life member of the association. Mrs. Perry was asked to draw up bylaws for the group.

SAINT JOHN

W. Hooser was re-elected to the presidency of the chapter at the annual meeting held earlier this year. Other members of the executive are: K. Donohue, H. McCul-

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Head Nurses: for Mental Health Centre. Postgraduate course in Psychiatric Nursing or equivalent experience.
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lum, vice-pres.; M. Cavanagh, sec.; Mrs. K. Earle, treas. The report of activities during the past year indicated that it had been a very busy and successful term. Included in the list of guest speakers during the past months were C. Wells, speech therapist of the cerebral palsy clinic in Lancaster, and Dr. T. E. Grant who discussed electrolyte balance. Chapter members also operated a tea room during the city exhibition. Proceeds were used to help pay the tuition of a boy engaged in physical education studies. In October the local chapter was hostess to delegates attending the provincial convention.

General Hospital

Forty-eight students received their caps from Miss J. Stephenson, director of nursing, in an impressive candle lighting ceremony. The prayer of dedication was offered by Miss Ashley. Dr. A. Kirkland, the guest speaker, encouraged the students to follow the traditional ideals that have made nurses such valuable members of society.

St. Joseph's Hospital

Sister Helen Marie assisted by Sister Loretto presented caps to 27 students at a brief ceremony in the hospital chapel. Father Gallagher led the students in recitation of the capping pledge. A "capping dance" was held in the residence on the following evening.

ONTARIO

District 1

Chatham

Public General Hospital

Nearly 200 graduates attended a dinner honoring Miss Priscilla Campbell who retired in February after 35 years as administrator of the hospital. For 25 years of that time she was also the director of nursing. As a living memorial and tribute to her work the alumnae association announced that the "Priscilla Campbell Scholarship for Postgraduate Nursing Education" would be awarded each year at graduation to an outstanding student. Mr. Ralph Steele, representing the Board of Trustees; Mr. Richard Pearce, from the hospital staff; Miss B. Beattie, director of the school of nursing; Dr. L. Story from the medical staff; Mrs. C. Wright from the Blenheim chapter of the alumnae all paid tribute to Miss Campbell.

On the same occasion, Miss Lillian Maynard was also an honored guest. She recently completed 50 years of active nursing. The speaker for the evening was Dr. F. Reid who entitled his talk "Around the World in 46 Days." Dr. Reid described his impressions of people, hospitals and medical and surgical technique in fourteen countries visited during a tour by a group of members of the International College of Surgeons.

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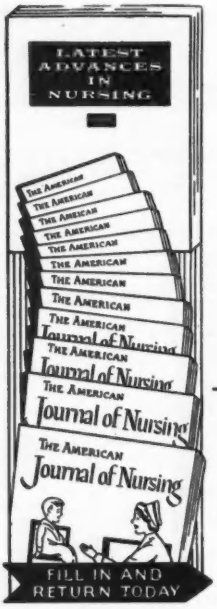

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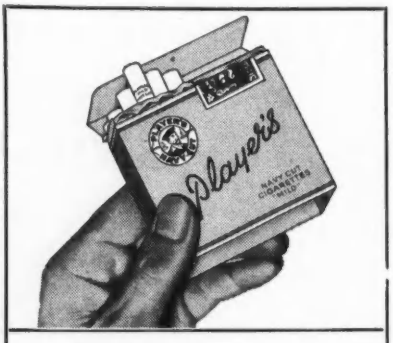

Player's Please

THE MILDEST
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District 1

London

Victoria Hospital

Eighty-one student nurses were welcomed into the school by Miss E. M. Robson at the recent capping exercises. J. Watmough, president of the preclinical class, replied to the welcome. The guest speaker for the evening was Miss Edith McDowell, Dean of the school of nursing, University of Western Ontario. Each newly capped student was presented with a Nightingale lamp on behalf of the alumnae association.

Alumnae members are reminded that the school of nursing will celebrate its 75th anniversary in 1958. A homecoming of graduates is planned and preparations are already underway for this event. B. Wilkins has joined the staff of Kitchener-Waterloo Hospital as supervisor of the pediatrics department. P. Huddleston is on the staff of the Vancouver General Hospital. M. Drummond has returned to the Fort William branch of the Ontario Society for Crippled Children following postgraduate study in public health at the University of Toronto. M. Lankin is on furlough from her work in French Equatorial Africa. Mrs. M. (Clendennan) Yates is also on furlough from West Africa where she and her husband are

serving as medical missionaries. E. Schumacher is presently on the staff of Peterborough Civic Hospital. Mrs. R. (Young) Britton is a staff member of the local branch of the Ontario Cancer Foundation Clinic.

District 4

Fonthill

Four hundred nurses attended the annual district meeting held late in 1956. The guests included Miss Florence H. Walker, Miss Margaret Morgan and student nurses from the local schools of nursing. The guest speaker was Lieut. Com. Charles T. McNair who gave an interesting address about the ships and the men of the Royal Canadian Navy. The film "The Navy Goes North" concluded the program.

Installation of the new slate of officers was carried out by E. Ewart. The executive includes: E. Ferguson, pres.; Mrs. G. Lewis, E. Bingeman, vice-pres.; M. Squire, sec.; C. Leleu, treas.

Niagara Falls

Greater Niagara Hospital

This is an anniversary year for the alumnae association. Plans are in progress for a three-day celebration to be held in September in conjunction with graduation exercises. It is hoped to have a reunion of past graduates as part of the observance of this 50th anniversary. Guests to the city will be billeted in the homes of members. It is anticipated that the new residence will be open.

District 5

Toronto

General Hospital

A. Maksinuk who has been with T.C.A. in Winnipeg was recently posted to Malton. M. J. B. Thompson is a supervisor at the new Queensway Hospital where M. Ogden and G. Rohr are also on staff. M. Duncan is working in Oakland, California. E. Hurst and F. Hewton are doing private duty following their return from England. R. (Billings) Cughan is working in a doctor's office in Brockville. J. Le Pan has accepted a position as inspector of nursing schools in Ontario.

The Mary Agnes Snively bursary is to be awarded during this year. It is available to graduates of the hospital who wish to continue their studies in any recognized university. The value of the bursary is $1,000.

Women's College Hospital

The annual meeting of the alumnae association was held late in January. An informal supper party was followed by a business session. Members were asked to submit pro-

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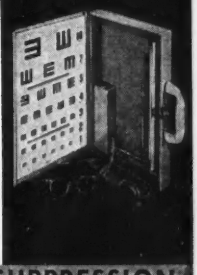

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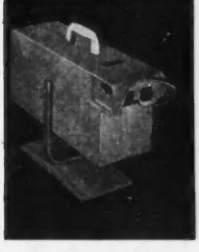

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gram suggestions to any member of the executive. Miss Macham addressed the group briefly concerning recent hospital improvements. Members elected to office included: E. Fraser, pres.; S. Sheppard, M. Mills, vice-pres.; Mrs. N. Kent, treas; Mrs. P. McMillan, rec. sec. Ila (Barkery) Honsberger, presently on furlough from the mission fields, was the guest of honor at a class reunion organized by C. Goodison. Isabel (Munn) Fogo is an instructor at the Provincial Government School for Nursing Assistants. D. Rogers, who has been on the staff of the New Mount Sinai Hospital as evening supervisor, has been awarded a $1,000 bursary by the Auxiliary of the Hospital. She is presently attending the University of Toronto School of Nursing. V. Taube is also enrolled at the University of Toronto. Y. Burnsides, D. Bremner, P. Bryant and L. Bernache plan to attend the International Congress of Nurses in Rome.

DISTRICT 6

BELLEVILLE

General Hospital

The annual bridge party was held in mid-February at the Y.M.C.A. Dr. Douglas was the guest speaker at the March meeting of the alumnae association. His topic was "Recent Advances in Surgery." A scrap book containing clippings about alumnae members has been started with Mrs. M. Bieman as historian. She would appreciate hearing from members who could assist in collecting these items. The student nurses held a "Penny Sale" in February.

DISTRICT 7

KINGSTON

Ontario Hospital

Noreen Foster, Marilyn Bryans, Janke Sjaarda, Margaret Hodgson, Barbara Wickett and Mary Lee received their caps from Miss E. G. Smith, superintendent of nurses, assisted by members of the teaching staff. A candle lighting ceremony followed and recitation of the Nightingale Pledge. Mrs. C. H. McCuaig presented *The Canadian Nurse* award to B. Wickett. The guest speaker for the evening was Miss Isabel Laird, professor of psychology, Queen's University. Reverend J. Scanlan pronounced the benediction at the close of the ceremony. Dr. Paul Christie provided processional music during the evening. A very pleasant social hour followed.

DISTRICT 8

OTTAWA

Univ. of Ottawa and General Hospital

The alumnae association donated a Foster reversible bed to the neurosurgical floor and an electrical portable suction to the

central supply room. The annual bazaar held late last year was a decided success under the convenership of Mrs. Dora Kipp. The members of the graduating class were guests of honor at the Valentine party.

QUEBEC

MONTREAL

Instructors' Group

The second general meeting of the instructors' group took the form of a panel discussion. The panelists were: Sr. M. Felicitas, Dr. Chittick, Dr. A. Ross, Mrs. I. McLeod and Miss A. Gage. The discussion was opened by Sr. Felicitas with a quotation from Dr. Weir's report on nursing education in Canada. The panel members took up the problem of why nursing and nursing education have lagged behind current social changes and pressures.

The feeling was expressed that education in hospitals does not develop maturity. Hospital hierarchy and rules, collective thinking and behavior to cover emergencies, all serve to stifle curiosity and imaginative thinking. The accent that present teaching methods tend to place on procedure rather than on principles further inhibits the student's ability to deal with nursing situations in the community or hospital. Emphasis should be placed on the development of the nurse as a woman having initiative, originality, and sufficient outside interests to be an interesting person as well as a nurse.

Royal Victoria Hospital

Plans are underway for the annual alumnae dinner in honor of this year's graduating class. It will be held on May 6 at the Ritz Carlton hotel. Dr. Douglas Wilson of *The Montreal Star* will be the guest speaker.

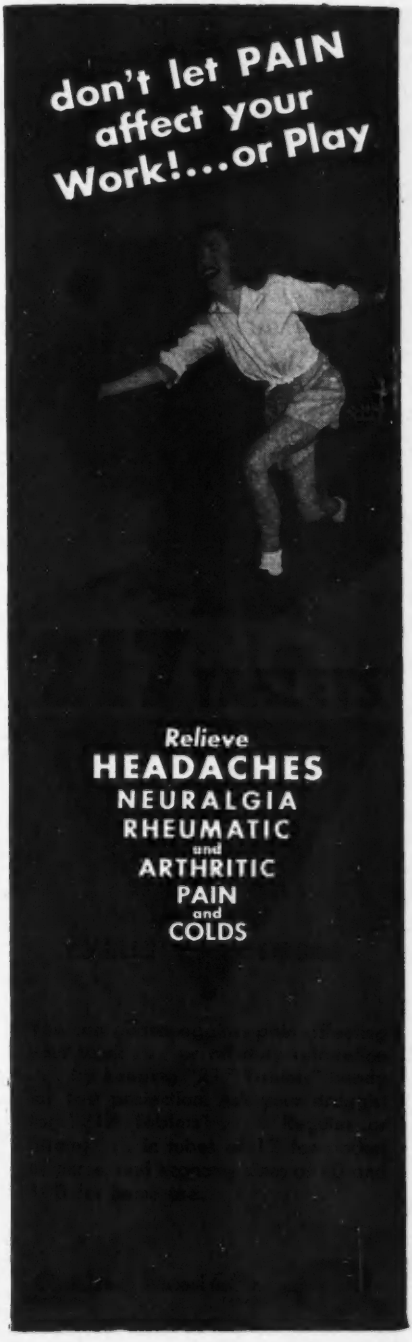
Dr. T. R. Dodds discussed the development and work of the Well-Woman Clinic at a recent general meeting. The Moncton chapter plan to have a buffet supper late in the Spring for all New Brunswick members. G. Abrams was elected president of the chapter and A. Bulman, secretary. K. McLennan is doing postgraduate study in psychiatry at the Allan Memorial Institute.

SHERBROOKE

Sherbrooke Hospital

The executive of the alumnae association includes the following members: Mrs. M. Mandigo, pres.; Mrs. G. Bryant, Mrs. T. A. Savage, vice-pres.; T. Graham, rec. sec.; E. Cutts, treas.

Elected to office in the staff association were: A. McElrea, chairman; J. Keating, vice-chairman; B. Desruisseaux, sec.; L. Fortier, treas. Mrs. R. Kimoff, the guest speaker at a recent meeting, described nursing in Newfoundland — in particular at the Grenfell Mission, St. Anthony. M. Aldrich is presently working at the Mission.



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Registered or **Graduate Nurse** for 83-bed Nursing Home for the aged. Pleasant surroundings. Annual vacation, statutory holidays, sick leave benefits. Employee to live out. Salary dependent on qualifications. For further particulars apply Administrator, John Noble Home, Mt. Pleasant Rd., Brantford, Ontario.

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Registered Nurses for General Duty. Initial salary: $200 per mo., with 6 or more months Psychiatric experience, $210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

Registered General Duty Nurses for 43-bed General Hospital. Apply Superintendent, District Memorial Hospital, Huntsville, Ontario.

Registered General Duty Nurses for 50-bed General Hospital in South Western Ontario. Apply Superintendent, Leamington District Memorial Hospital, Leamington, Ontario.

Registered General Duty Nurses for 30-bed hospital. Apply Superintendent, General Hospital, Meaford, Ontario.

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Registered Nurses (2), Practical Nurses (2) at the United Church Mission Hospital, Hazelton, B.C. An opportunity for Christian service. Monthly salary: R.N.'s, $225, P.N.'s, $175. Write Administrator, Wrinch Memorial Hospital, Hazelton, B.C. or if in Toronto contact Dr. M. C. Macdonald, Board of Home Missions, 299 Queen St. W., Toronto 2B, Ontario.

Registered General Duty Nurses for County Hospital in Huntingdon, 45 mi. from center of Montreal. Excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. 2 theatres, bowling, curling & dancing. 8 mi. from summer resort on Lake St. Francis & 12 mi. from U.S. border. Gross salary: $200 per mo. Three $5.00 increases at 6-mo. intervals to maximum $215. 44-hr. wk., 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 2-wk. sick leave. Blue Cross paid. 1 mo. annual vacation, all statutory holidays. Apply Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Que.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $200 per mo., additional monthly bonus for permanent evening & night shifts 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered Nurses for an accredited 82-bed hospital. Salary: $225-$245 per mo. 41-hr. wk., no split shifts. 30-day vacation with pay after 1 yr. of service plus statutory holidays. Living accommodation in nurses' residence & laundry of uniforms provided for $8.00 to $12 per mo. Apply Superintendent of Nurses, Union Hospital, Canora, Sask.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses (Male & Female). Starting salary: $300 up, plus $20 p.m. shifts. 40-hr. wk. Paid vacation, 10-days sick leave. Social Security, hospital group ins. Apply Mr. Glenn A. Dickau, R.N., Administrator, Memorial Hospital, Corning, California.

Attention Registered Nurses — Apply Now! Staff positions available starting June '57 for 400-bed country hospital located 2 hr. drive from either San Francisco or mountain resort areas. Starting salary: $304 with shift differential of $10. Specialty service differential also. Rooms available in nurses' home for $15 per mo. Laundry & meals available for a reasonable sum. 40-hr. wk. 3-wk. vacation at end of 1 yr. 11 holidays yearly & compensatory sick time. Apply Director of Nurses, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Registered Nurses (Under 50) General Duty: $315-$330 depending on experience. **Supervising positions:** $330-$375 on step-basis. 3-wk. vacation, 11 holidays. Sick leave benefits, retirement plan. Modern Nurses' residence. State eligibility for California registration. Tuberculosis, other chest diseases, chronic illness. Rehabilitation ward recently opened. Interesting & challenging positions for qualified R.N.'s. Submit photo to Director of Nursing Services, Tulare-Kings Counties Hospital, Springville, California.

Registered Nurses (Male & Female) for 325-bed hospital. Salary: $300. Differential: $20, evenings; $15, nights. 40-hr. wk. Liberal personnel policies. Low cost cafeteria. Apply Director of Nursing, St. Anthony's Hospital, 2875 W. 19th St., Chicago, Illinois.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good persnnnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses for 398-bed J.C.A.H. non-sectarian research & teaching hospital with N.L.N. fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Housing available at reasonable rates. Apply Director of Nursing Service, Mount Sinai Hospital,, 1800 East 105th St., Cleveland 6, Ohio.

Registered General Duty Nurses (All Departments) for 650-bed teaching hospital located in southwestern Ohio. Good salary program. 40-hr. wk., paid vacation, liberal employee benefits. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

Registered Nurses for staff nursing in new & beautifully equipped 100-bed hospital in the Pacific northwest. Only 6 mi. from the Pacific Ocean. Delightful climate. Beginning salary: $290 for 40-hr. wk., $10 additional for p.m. & night duty. Apply Director of Nurses, County General Hospital, Tilamook, Oregon.

Registered Nurses for 85-bed General Hospital, near border of Mexico. City of 22,000. Splendid climate. 360 days sunshine. Base salary: $275 with interval increases. 2-wk. vacation. 2-wk. sick leave. Retirement. Apply Memorial General Hospital, Las Cruces, New Mexico.

General Duty Nurses for the R.W. Large Memorial Hospital of the United Church of Canada, at Bella Bella, B.C. 300-mi. north of Vancouver on the B.C. coast. Salary: $240 per mo. less $40 for room, board & laundry of uniforms. 2 annual increments of $5.00 per mo. Sick time: 1½ days per mo. cumulative. 1 mo. annual vacation plus 10 days in lieu of statutory holidays. Transportation refunded after 1 yr. Apply Matron.

General Duty Nurses. Salary: $240-$280, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses & Operating Room Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary $240-$273. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for 40-bed active hospital. Salary: $250 per mo. less $45 full maintenance in comfortable nurses' home adjacent to hospital. 42-hr. wk. Rotating shifts. 28-day annual vacation plus 10 statutory holidays. Cumulative sick time. This is an active friendly community located on the scenic Hope-Princeton highway with easy access to the beautiful Okanagan or westward to Vancouver. Apply Director of Nursing, General Hospital, Princeton, B.C.

General Duty Nurse: The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses' residence. For further information apply to Superintendent of Nurses.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses. Starting salary: $225 monthly with additional $5.00 per mo. for each yr. of experience since graduation up to 4 yrs. Annual increment: $120. Maximum salary: $255. Blue Cross paid by hospital. Room & board available in nurses' residence, $45 monthly. Transportation costs refunded after 6 mo. employment. Apply Director of Nursing, General Hospital, Atikokan, Ontario.

General Duty Nurses for 55-bed hospital. Salary: $200 per mo. plus maintenance. Travelling expenses refunded on completion of 12-mo. service. Apply Director of Nursing, The Lady Minto Hospital, Chapleau, Ontario.

General Duty Nurses for 86-bed hospital. Situated in the heart of vacation land on Georgian Bay with 7 mi. of sand beach, & is noted in winter for its great skiing on the Blue Mts. Gross salary: $185 for non graduate; $190-$210 for graduates. 44-hr. wk. Statutory holidays. Employee benefits. Living accommodation available. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for modern 60-bed hospital in Southwestern Ontario. 5½ day wk. 3-wk. annual vacation. 7 statutory holiday. Accumulative sick time. Free laundry. The hospital pays ½ of hospitalization plan for each staff member. Apply Director of Nurses, Alexandra Hospital, Ingersoll, Ontario.

General Duty Nurses for 107-bed accredited hospital. Starting salary: $190 per mo. plus meals. Differential for evening & night duty. Periodic increases. Travelling expenses from point of entry into Ontario refunded after 6-mo. service. 44-hr. wk. 21-days vacation with pay, 8 statutory holidays. Accumulated sick time. Medical & hospital plan subsidized. Room accommodation available in residence. Apply Superintendent, of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

General Duty Nurses for all departments. Gross salary: $215 per mo. if registered in Ontario, $205 per mo. until registration has been established. $20 per mo. bonus for evening or night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses (Immediately) for operating room. Good salary & good personnel policies. Apply Director of Nursing, Ottawa Civic Hospital, Ottawa 3, Ontario.

General Duty Nurses (2) for new 173-bed hospital. Good personnel policies. Starting salary: $215 per mo. 44-hr. wk. Apply Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

General Duty Nurses for 650-bed teaching hospital in central California. Salary: $303-$356 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

General Duty Nurses for new, ultra modern 200-bed General Hospital on San Francisco Bay. Salary: $320 per mo. plus $20 differential for evenings & nights. Liberal personnel policies. Apply Director of Nursing, Brookside Hospital, San Pablo, California.

General Duty Nurses (Staff positions in all Clinical areas) for 260-bed teaching hospital located half way between Detroit & Chicago. Day duty: $271 per mo. Evening & night duty: $301 per mo. 40-hr. wk. 2-wk. vacation. 2-wk. sick leave. 6½ holidays. Social security & group insurance. Apply Director of Nurses, Borgess Hospital, Kalamazoo, Michigan.

General Duty Nurses for modern Hospital. Gross salary: $275. 44-hr. wk. Write Greenbush Community Hospital, Greenbush, Minnesota.

General Duty Nurses for newly opened 100-bed General Hospital located in Victoria, Texas. Pop. 50,000. Good year round climate, many recreational facilities. Starting salary: $275, differential for 3 to 11 & 11 to 7. 40-hr. wk. Liberal personnel policies. Apply to Director of Nursing, Citizens Memorial Hospital, Victoria, Texas.

General Duty Nurses for 50-bed General Hospital with excellent facilities. Complete X-ray, laboratory, physiotherapy, surgery, medical records & dietetic depts. Located in scenic Wyoming near Yellowstone National Park. Salary: $280. Apply stating qualifications, experience, housing desired etc. in first letter to Superintendent of Nurses, W. R. Coe Memorial Hospital, Cody, Wyoming.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & post graduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $300 with 4 annual increases to $341. Full maintenance $45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses for fully accredited private teaching hospital, located on Lake Michigan just north of Chicago. Salary range: $320.05-$346. Shift bonus: $26, afternoons; $17, nights. 5-day, 40-hr. wk. Progressive personnel policies. Excellent cafeteria & attractive rooms at reasonable rates. Please indicate type of service preferred. Apply Director of Nursing, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

Staff & Operating Room Nurses for 225-bed General Hospital, near New York City. Salary: $280 including benefits; $30 bonus for evening, $25 for night, extra for call duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, New York.

Staff Nurses for modern 650-bed Tuberculosis Hospital affiliated with Western Reserve University approved by joint commission on accreditation of hospitals. 40-hr., 5-day wk. Beginning salary: $286 with automatic increases. Advancement for eligible applicants. Full maintenance available at minimum rate, housing for 2 or more nurses. Meets approved minimum employment standards of the State Nurses' Association. Apply Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Graduate Nurses (4) for permanent staff Municipal Hospital. Net salary $180 per mo. with full maintenance. At the end of each 6-mo. period on staff Graduate nurses will receive a bonus of $120 thus making the net salary in effect $200 per mo. before income tax. 2 day vacation time in earned each full mo. worked, 8 statutory holidays in addition. Liberal sick pay & free hospitalization included in plan. We have a very nice residence for the nursing staff & are only 2 hrs. from Calgary by Trans-Canada highway or C.P.R. main line. You will like it here. Apply Matron. Municipal Hospital, Bassano, Alta.

Graduate Nurses for 125-bed maternity hospital & operating rooms of the Royal Alexandra Hospital. Personnel policies on request. For particulars apply Director of Nursing, Royal Alexandra Hospital, Edmonton, Alberta.

Graduate Nurses (3) for 64-bed active hospital. Salary: $225 per mo. if registered in Alberta less $30 per mo. for room & board. 4-wk. vacation after 1 yr. 9 statutory holidays. 1½ days sick leave per mo. Living accommodation if desired. Travelling expenses up to $50 will be refunded after 1 yr. of service. Apply Sister Superior, Providence Hospital, High Prairie, Alberta.

General Duty Nurses (2) for 16-bed hospital. Salary: $230 per mo. less maintenance of $25 per mo. Increase of $5.00 per mo. for each 6 mo. of service up to 2 yrs. Income tax deduction & Blue Cross on a 50-50 basis. 1 mo. annual vacation with pay after 1 yr. service. Hospital is centrally located between 2 lake resorts etc. Apply Miss E. L. Weaver, R.N., Matron, Municipal Hospital #43, Bentley, Alberta.

Attention! Attention! Vacancies are expected in an active 50-bed General Hospital close to Vancouver, B.C. R.N.A.B.C. personnel policies under revision. Present basic salary: $250 per mo. Accommodation in staff residence available. Apply Miss M.R. Ward, Supt. of Nurses, Langley Memorial Hospital, Murrayville, British Columbia.

Graduate Nurses (3) for 24-bed hospital. Salary: $235 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. accumulative. Apply, stating experience to Matron, Terrace & District Hospital Terrace, British Columbia.

Graduate Nurses (General Staff Positions) for General Hospital. Salary: $239. per mo. as minimum & $277.25 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

Graduate Nurses & Nursing Assistants Immediately for modern 42-bed hospital in northern Ontario. General salary schedule & allowances. 40-hr. wk. 1-mo. vacation with pay for Graduate Nurses. Apply Administration, New Liskeard & District Hospital, New Liskeard, Ontario.

Graduate Nurses for new, very modern 88-bed hospital in a pleasant progressive town Nurses salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital Orangeville, Ont.

Graduate Nurses for general staff duty in a tuberculosis hospital for treatment of adult medical patients. For further information, apply to Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Graduate Nurses for new $13,000,000 hospital. Salary: $3,700 per yr. Meals & laundry 40-hr. wk. Liberal vacation, holidays & sick leave. Civil Service benefits. Apply Director of Nursing, Martland Medical Center, Newark 7, New Jersey.

Nurses — eligible for registry — immediate openings for general duty & surgery. Starting salary: $275 per mo. 40-hr. wk. Maintenance furnished if desired. Hospital located 12 mi. south of Portland with educational & cultural advantages; near mountains & seashore. Apply to Director of Nurses, Oregon City Hospital, 515 Tenth St., Oregon City, Oregon.

Operating Room Nurse — Modern operating room. Salary $300 per mo. Ideal coast climate. Apply Director of Nursing, Matthews General Hospital, Burlington, Washington.

Laboratory Technician for 75-bed hospital. Attractive laboratory with excellent working facilities. Apply to Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

Technicienne de Laboratoire pour hôpital 100 lits. Adressez Hôpital St-Jean de Brébeuf, Sturgeon Falls, Ontario.

Supervisor (qualified.) Good salary. Extra allowance for experience if French speaking 5-day wk., 4-wk. vacation, 18 days sick leave accumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Public Health Nurses (Qualified) for generalized program. Salary: $3,000 to $3,600. Annual increment: $150. 5-day wk. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

Public Health Nurse for generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King. York County Health Unit, Newmarket, Ont.

Public Health Nurses (Qualified) for Generalized Program — City of Ottawa Health Dept. Salary: $3,192-$3,672. Good personnel policies. 5-day wk. Superannuation, Blue Cross & P.S.I. benefits. Apply Employment & Labor Registry Office, Room 118, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Public Health Nurses (Qualified) for generalized public health nursing service. Salary range effectively July 1, 1957: $3,388-$3,833. Starting salary based on experience. Annual increments. 5-day wk. Vacation. Shared hospitalization. Sick pay & pension plan benefits. Apply Personnel Dept., Room 320, City Hall, Toronto, Ontario.

Registered General Duty Nurses for new 50-bed General Hospital in active B.C. center. Starting salary: $235. 40-hr. wk. 28 days vacation, 10 statutory holidays. Sick leave, full benefits. Travel refund. Private accommodation in new nurses' residence. Offers convivial, harmonious atmosphere. Please state age, qualifications, references. Apply Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

The
Ontario Society for Crippled Children

requires

EXPERIENCED PUBLIC HEALTH NURSES

GOOD SALARY RANGE

and

PERSONNEL POLICIES

For further information apply to:

THE SUPERVISOR OF NURSING SERVICES,
ONTARIO SOCIETY FOR CRIPPLED CHILDREN,
92 COLLEGE STREET, TORONTO 2, ONTARIO

Public Health Nurse Grade 1. British Columbia Civil Service, Dept. of Health & Welfare Starting Salary $255, $260, $266 per mo., depending on experience, rising to $298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

Public Health Nurses (2) for generalized program in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group insurance available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scale: $3,000 for inexperienced nurses to start with annual increments of $150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ontario.

Public Health Nurses (qualified.) Salary: $3,100 depending on dist. served, less if in the Timmins area. Annual increment $150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative). Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Public Health Nurses (Qualified) for a generalized program in Etobicoke Township (suburb of Toronto). Minimum salary: $3,200. Starting salary based on experience. Car allowance $670 per annum. 4 wk. vacation after 1 yr. Blue Cross, Pension Plan & P.S.I. benefits. Apply Director of Public Health Nursing, Township of Etobicoke, 4946 Dundas St. W., Toronto 18, Ont.

Operating Room Supervisor for 86-bed hospital. Situated in the heart of vacation land on Georgian Bay with 7 mi. of sand beach, & noted in winter for its great skiing on the Blue Mts. 44-hr. wk. Statutory holidays. Employee benefits. Living accommodation available. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Operating Room Supervisor, Night Supervisor, Assistant Head Nurses & Staff Nurses. Excellent personnel policies. Apply Director, Shriners Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

McKellar General Hospital, Fort William, Ontario requires a **Science Instructor. Duties to** commence early in August. Salary schedule: $270-$300 per mo. Additional recognition for experience. Good personnel policies. Apply Director of Nursing.

Registered General Duty Nurses, 2: (May 1, 1957) for 76-bed fully modern hospital on C.P.R. main line & Trans-Canada Highway to Calgary & Banff. Gross salary: $230 per mo. Perquisites $30. $5.00 increment every 6 mo. 8-hr. day, 44-hr. wk. 1 mo. annual vacation with pay. Sick leave with pay. Apply to Matron, Brooks Municipal Hospital, Brooks, Alberta.

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a 3-month Course in the Advanced Study of Pediatric Nursing

This course is designed to be practical, geared to assist graduate nurses to cope with emergencies & problems of a physical nature, as well as understanding the continuous growth & development of each child. The child's relation to his family & its place in the community is an important feature of study.

Content is incorporated into an 8-hr. day, & a 5-day wk. Fifty percent of this time will be devoted to lectures & discussions; fifty percent to the practice of the art of nursing children.

For outline of the course & information regarding fees, apply to:

MISS J. I. MASTEN,
DIRECTOR OF NURSING

CHILDREN'S HOSPITAL OF WINNIPEG

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Registered Nurses (Immediately) for 30-bed hospital. Salary: $210 per mo. gross. Come & spend the summer months next door to Waterton Lakes National Park. Apply Matron of Municipal Hospital, Magrath, Alberta.

McKellar General Hospital, Fort William, Ontario requires **Registered General Duty Nurses.** Basic salary: $225 per mo. Good personnel policies. Hospital consists of a new wing & a recently completed extensive renovation program in the old section. Nurses interested in all fields of nursing are invited to apply to the Director of Nursing.

Registered or Graduate General Duty Nurses (2) for modern 20-bed hospital. Salary: $230, R.N.'s.; $220, Grads. Increment of $5.00 after each 6-mo. service. 1-mo. vacation with pay after 1 yr. service. Separate staff residence. Maintenance $30 per mo. Apply Matron or Secretary-Manager, Riverside Memorial Hospital, Turtleford, Sask.

Registered Nurses for 38-bed General Hospital. Salary: $265 with periodic increases. Excellent personnel policies. For further information apply Superintendent of Nurses, City Hospital, Red Wing, Minnesota.

General Duty Nurses for 50-bed hospital. 5½ day wk. 8-hr. duty. Annual vacation with pay & statutory holidays. Full maintenance in new modern residence. For full particulars apply Superintendent, General Hospital, Kincardine, Ontario.

General Duty Nurses. Starting salary: $248 per mo., $10 additional for 2 yr. continuous past experience. 4 annual increments of $10 per mo. to B.C. Reg'd. nurses. $20 per mo. for one or more years university training & $10 per mo. for hospital postgraduate clinical training of not less than 4 mo. 28 days annual vacation after 1 yr. service, 10 statutory holidays per yr. 1½ days sick leave per mo. cumulative. Room rent at nurses' residence $20 per mo. Promotions to senior positions from permanent staff. For details apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

TORONTO GENERAL HOSPITAL

Department of Radiotherapy & Ontario Cancer Institute

RADIOTHERAPY NURSE — TECHNICIANS

A 2-yr. course in technical training is offered by the above dept. to Graduate Nurses, with senior matriculation, interested in this type of work which embraces every aspect of radiation therapy. Salary during training approx. 90% of the basic for Registered General Staff Nurses. Inquiries are invited, and may be addressed to:

DR. M. V. PETERS, Dept. of Radiotherapy, Toronto General Hospital, Toronto 2, Ontario.

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Personnel Practices Provide:

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For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada,
193 Sparks Street, Ottawa 4, Ont.

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REQUIRES

SUPERVISOR OF NON-PROFESSIONAL PERSONNEL
Position available June 1.

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Position available August 1.

Good personnel policies. Salary commensurate with qualifications & experience.

For further information apply:

DIRECTOR OF NURSING,
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GENERAL STAFF NURSES

OBSTETRICAL SUPERVISOR (QUALIFIED)

300-BED GENERAL HOSPITAL.

EXCELLENT PERSONNEL POLICIES.

For further information apply:

DIRECTOR OF NURSING,
MEMORIAL HOSPITAL, REGENT ST. S., SUDBURY, ONTARIO.

The Board of Governors
KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

Invites applications for two senior positions

1. **GENERAL SUPERINTENDENT**
2. **DIRECTOR OF NURSING**

The openings become available by the voluntary retirement of the two present officials to be effective when replacement can be arranged.

SALARY OPEN - APPLY TO SECRETARY OF THE BOARD OF GOVERNORS, KINGSTON GENERAL HOSPITAL, KINGSTON, ONTARIO.

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SAINT JOHN
GENERAL HOSPITAL
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Saint John, New Brunswick

150 students

New modern teaching department

400-bed hospital

Duties to commence August 15, 1957

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TORONTO HOSPITAL

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ONTARIO

Applications are invited from graduate nurses for general duty staff appointments in metropolitan Toronto. Opportunities for advancement. Pension plan. Accumulative sick leave. Residence for nurses available. Also postgraduate course.

For further information apply to:

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Toronto Hospital for T.B.,
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ST. JOHN'S
EPISCOPAL HOSPITAL

480 HERKIMER STREET
BROOKLYN 13, N.Y.

An acute general hospital of 281 beds. Fully accredited. Located within the city limits. Close to shopping and entertainment areas.

VACANCIES — A limited number of staff positions in most areas.

ATTRACTIVE living accommodations.

SALARY — Begins at $260 - $265 per month depending on shift.

INCREMENTS — $10 at the end of 3 and 12 months. $5 at end of 24 months.

BONUS — $40 for evening duty — $20 for night duty.

HOLIDAYS — Eight paid holidays per year.

VACATION — Four weeks after completion of 1 year.

SICK LEAVE — 15 days after 1 year.

HOSPITALIZATION and other benefits.

BENEFITS — begin after 6 months.

Apply to:

DIRECTOR OF NURSES

THE GENERAL HOSPITAL OF PORT ARTHUR
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NURSING ARTS INSTRUCTOR — SCIENCE INSTRUCTOR
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Excellent salary & personnel policies.

1 CLASS A YEAR ADMITTED TO SCHOOL. MODERN TEACHING UNIT.

APPLY TO: DIRECTOR OF NURSING SERVICE.

CLINICAL INSTRUCTOR
IN
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for a modern well-equipped school. Recent University postgraduate course and teaching experience preferred.

Annual salary range: $3,302 - $3,770.

Apply:

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REGISTERED NURSES
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Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan.

Apply stating age, qualifications to:

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Starting salaries up to $3,450

All will serve in hospitals operated by Veterans Affairs or National Health & Welfare at various centers across Canada.

University graduation in Physiotherapy or Occupational Therapy is essential, & for the higher positions some experience is necessary.

Details & application forms at main Post Offices, main National Employment Offices & Civil Service Commission Offices.

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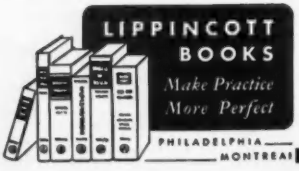

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